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SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, January 8, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 min)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.1a Presentation of Commendation for KQED's Bay Window

The Mental Health Board will present the commendation to Michael Isip, Producer of "Hope on the Streets", approved by resolution on November 13, 2002.

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of November 13, 2002, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 8, 2003, to the following members: none

2.0 PRESENTATION: MENTAL HEALTH COURT (45 min)

Judge Harold Kahn will present the plans for a Mental Health Court in San Francisco.

3.0 DIRECTORS REPORTS (30 min)
For discussion

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (20 min)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The chair will report discussions and actions of Executive Committee.

4.1 a PROPOSED ACTION: Be it resolved that the Mental Health Board adopts the following priorities for the year 2003:

1. Advocacy for the mental health budget
2. Participation in planning for Behavorial Health Services integration
3. Monitor implementation of Proposition N, "Care Not Cash"

5.0 NEW BUSINESS (10 minutes)

Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (10 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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MENTAL HEALTH BOARD
ATTACHMENT A
January 8, 2003

CONSENT CALENDAR
All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a **PROPOSED RESOLUTION: Be it resolved that the minutes of the Mental Health Board meeting of November 13, 2002, and the Retreat notes for December 7, 2002, be approved as submitted.**

1.2.b **PROPOSED RESOLUTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 8, 2002, to the following members: none.**

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MENTAL HEALTH BOARD
ATTACHMENT B
September 11, 2002

PROPOSED RESOLUTION (MHB-2003-xx)
PRIORITY ISSUES FOR 2003

BE IT RESOLVED, that the Mental Health Board, in concordance with its state-mandated duties and contractual duties, will focus priority attention and action on the following three issues during 2003:

1. Advocacy for the mental health budget for 2002/03 and 2003/04.
2. Participation in planning for integration into the new Community Behavioral Health Services.
3. Monitoring the implementation of Proposition N, "Care not Cash."

and,

BE IT FURTHER RESOLVED, that the Executive Committee of the Board may at any time make recommendations to the Board about altering or amending these priorities in response to new information, events, or crises, or in the case that any of the priorities is completed or becomes irrelevant.

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The Mental Health Board meeting scheduled for December 11, 2002, has been CANCELED

The Board will be holding its Annual Retreat on Saturday, December 7, 2002, Hotel Nikko at 222 Mason Street, from 9 a.m. to 4 p.m.

No final votes will be taken by the Board at the Retreat. Any proposals or resolutions developed by the Board during the Retreat will be placed on the agenda for public comment and to be voted on at its next regular meeting on **Wednesday, January 8, 2003.**

An agenda for that meeting will be sent out at the end of December.

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UNADOPTED MINUTES
Mental Health Board
Wednesday, January 8, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; hance martin; Toye Moses, Ph.D., M.P.H.; Rose Chung for Supervisor Aaron Peskin; Kate Walker; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bob Douglas; Dorothy Shaffer, R.N., N.P., M.S.N.

BOARD MEMBERS ABSENT: Dennis Yun, M.S.W.

PRESENTER: Judge Howard Kahn, Superior Court of San Francisco

OTHERS PRESENT: Linda Wang (Director of Adult Services, Community Mental Health Services); Michael Isip (KQED); Dede Ranahan (SFSU); Welyn Bui (Public Health Division, Eli Lilly & Company); Emeric Kalman; Mickey Shipley (San Francisco Network of Mental Health Clients, Mental Health Association, Citywide Alcoholism Advisory Board); Mike Wise (Voices at Bay, San Francisco Network of Mental Health Clients); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 CALL TO ORDER AND CONSENT CALENDAR

1.1 Call to Order and Announcements from the Chair
The meeting was called to order at 6:34 p.m. by Ted Stinson, Chair.

1.1.a Mr. Stinson: I want to start by saying welcome to the members of the public. It's great to have such a large turnout tonight. Next, we would like to present our commendation to "Hope on the Street", which I recommend highly if you haven't seen it. It's uplifting, moving, and sad. Michael Isip, the producer of the program is here tonight to receive the commendation.

COMMENDING AND THANKING KQED FOR PRODUCING AND AIRING "HOPE ON THE STREET"
WHEREAS, the problem of the homeless mentally ill on our streets is one that has not been well understood by the public, leading to a general sense of hopelessness and frustration about the issue, and

WHEREAS, California has provided funding for assertive and innovative outreach and case management programs which are proving themselves to be more effective than any approach attempted in the past, and

WHEREAS, people suffering from mental illness say the stigma against mental illness is often worse than the illness itself, and whereas, this stigma prevents an estimated 80 percent of mentally ill individuals from seeking treatment, and

WHEREAS, KQED through its program BayWindow, has produced an engaging, revealing, and sensitive documentary called "Hope on the Street," and

WHEREAS, "Hope on the Street" provides the uplifting message that there is hope for the mentally ill, even those living on the street, and that many of them can lead stable, fulfilling lives when given access to quality care, and

WHEREAS, this program will be shown throughout the country, will be used for inservice trainings for mental health professionals, and for years to come will be shown directly to the homeless mentally ill, inspiring them to seek treatment and stay with it, so they can live productive and healthy lives, now, therefore

BE IT RESOLVED, that the San Francisco Mental Health Board commends KQED for its commitment to producing "Hope on the Streets," a program of the very best quality and of great social value, and be it

FURTHER RESOLVED, that the Mental Health Board expresses its sincere gratitude to everyone who participated in creating, producing, and promoting "Hope on the Street," including most especially:

Michael Isip, Producer
Elizabeth Pepin, Associate Producer
Robert O'Geen, Editor
Sevda Eris, Outreach Coordinator
Sue Ellen McCann, Executive Producer

Mr. Isip: On behalf of KQED, I want to thank you very much for this commendation. I am incredibly honored and flattered. It means that our work has had an impact. "Hope on the Street" will be distributed nationally on PBS, which is great news. Starting in the spring, I'm confident that there will be a lot of interest.

I wanted to acknowledge my colleagues and a lot of people who participated. There were so many people who worked on this. Weilyn Bui, who is representing our funder, Eli Lilly and Company, is here. I thank them for stepping up to the plate. Dede Ranahan and her advisory board were instrumental in making sure we treated this topic fairly and accurately.

You should know that this program, "Hope on the Street", is just one part of a much larger effort to engage the Bay Area community to promote wellness and recovery. Colleagues are doing other stories to accompany this program. Our website is a resource for counselors and family members, giving them a mental health road map, and dealing with access. We're taking this out into the community. We did a large event at UC Berkeley. On March 1, we're doing a symposium for educators to focus on early identification and intervention in classrooms. In May, we have an event for departments of public health to train outreach workers. In July, we have an event with the Mental Health Association of San Francisco to target families.

The last thing I want to say is that this recognition is icing on the cake for me. It's been a remarkable journey making this. It's been three years in the making. Along the way I've met a lot of heroes, such as the people at the South of Market Clinic, and Mike Wise who's here tonight. The people in the program, and the families taught me that you can never give up on hope.

Mr. Stinson: It struck me as I was listening to Michael's comments, I can see that the challenges ahead of us are daunting. But seeing something like this on TV is a success. It's another battle in the war against stigma that we are fighting. It's another win.

Ms. Ranahan: I'm with the Mental Health Education & Workforce Development project of the College of Extended Learning at San Francisco State University. In partnership with KQED, we got a national grant to help with the video and the outreach effort. On March 1, we have a program targeting educators, from preschool to postgraduate, along with medical professionals, family, students, and everyone actually. The concept is to bring the mental health system and the education system together. We want to get mental health into everything, language lessons, history lessons, and cultural lessons. We're attacking the problem from the inside out. We're starting to make kids aware early. We want to start working on this at a very young age.

The program on March 1, 2003, at the South San Francisco Conference Center, is called "Promoting Mental Health in our Schools." We'll be featuring Stephen Mayberg, the Director of the State Department of Mental Health, along with Robert Corrigan, the President of the University. For more information go to www.cel.sfsu.edu and type "symposium" in the search field.

1.2 Consent Calendar

1.2.a **RESOLUTION (MHB-2003-01): Be it resolved that the minutes of the Mental Health Board meeting of November 13, 2002, and December 7, 2002, be approved as submitted. (Passed unanimously.)**

1.2.b **RESOLUTION (MHB-2003-02): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of January 8, 2003, to the following members: Bob Douglas, Dorothy Shaffer. (Passed unanimously.)**

Mr. Stinson: One of our Board members, Rick Nizzardini has had to leave the Board and wanted to be able to say a few words about this.

Mr. Nizzardini: I'm now working in the system, so that means I am not eligible to be on the Board any longer. I wanted to say goodbye to all of you whom I worked with in the past six months. The most difficult part of taking my new position was leaving the Mental Health Board. I had a couple sleepless nights making this decision because of that. I will continue to participate as part of the Program and Services Committee as regularly as I can. I want to thank everyone for the opportunity of being on this Board.

2.0 PRESENTATION: MENTAL HEALTH COURT

Mr. Stinson: Our main presentation this evening is by Judge Harold Kahn. He has almost 20 years experience in the law, both public and private. In April 2001, he was appointed to the Superior Court by Governor Davis. I am excited to have him speak to us about the Mental Health Court, which is relatively new to us and to the community as well.

Judge Kahn: The first thing I want to tell you is that this is a good day to talk about this topic, because the Mental Health Court had its first session today at 2 p.m. in Dept. 22. I am not the judge of that court, but I have been involved in the planning process.

It is a specialty court within the criminal justice system. We have two other specialty courts. A specialty court is limited in the matters it hears by subject. The two other courts are Drug Court and Domestic Violence Court. I am the judge of both of those courts, and it is through my experience with those courts that I got interested in this new court.

It is called the Behavioral Health Court. The Department of Public Health asked that it be called that.

I am talking about a component of the criminal courts that we have at 850 Bryant Street. A year and a half ago when I was appointed, I was told I was going to go to the criminal courts and I had not spent a day in my life in criminal courts. I was first assigned to general misdemeanors. It quickly became apparent to me that we have a lot of people in the criminal justice system with mental health issues. The criminal justice system became by default the system by which mental health issues were addressed or not addressed. The largest mental health institution we have in this city is the San Francisco County Jail. Six months after I was appointed, I was asked to take over the Drug and Domestic Violence Courts. I got to learn over the past year about this new wave of court programs catching on all over the country and around the world.

Drug courts are the model for mental health courts. The concept of a drug court is very simple. It's an alternative to incarceration. It is treatment-based. It is collaborative; it is done by consensus; it is not adversarial. There is a team that meets, including substance abuse treatment providers, a representative of the district attorney's office, and the defense attorney. The team meets to discuss the people who will appear in the court that day. We talk about: How best to help the person get off drugs and get them out of homelessness; how to engage them in treatment and get them employed. The goal is that they will succeed in turning their lives around, and then be rewarded by having the criminal charges dismissed. This is a revolutionary idea. It started in 1989 in Miami and

caught on like wildfire. Drug court first came to California in 1993, and San Francisco started its Drug Court in 1995. There are now over 1,000 across country.

We have 500 people who have graduated from our Drug Court. The vast majority of them have been long-time addicts, who have been in and out of institutions. By the end of Drug Court they had housing, were in employment, at school, or on disability. They had reunions with family members.

This is a voluntary court. The clients are typically facing serious jail time. Typically they are charged with selling cocaine, heroin, or amphetamines, and are facing six months or more in county jail.

It's a confidential court in that all information is shared with everyone on the team, but that information cannot be used if that person is unsuccessful in drug court and has to be returned to criminal court.

It is a court that is limited only to people who have charges against them, direct drug charges or charges related to drugs, like burglary for the purpose of supporting their habit. Because of this limitation, there are a lot of people who are left out of the possibility of participating in a treatment court.

Beginning in the late 90's, judges, defense attorneys, and public health staff came together, saying Drug Court has been so successful, let's see if we can extend this to mental health.

The first mental health court I'm aware of started in Anchorage, Alaska, in 1996. There are now about 50 mental health courts in the country. There are ten that are well regarded, including three in California: 1) Santa Clara. It is based in the San Jose criminal courts. The judge is Steven Manley. 2) San Bernadino. 3) Riverside.

Standards are set to determine which people are allowed into court, how often they come to court, and the criteria for success and failure.

As a San Franciscan, I like to believe we were at the forefront of progressive and thoughtful initiatives. Last summer I nosed around and found out that there were people who were interested in a mental health court, including people from the Mentally Ill Offenders program, the Center on Criminal and Juvenile Justice, and a colleague of mine, Kay Tsenin, who is the unofficial head of the criminal court. A few people had made field trips to other mental health courts. This collection of a few people decided to see if the criminal justice community wanted to create a mental health court. The response was overwhelmingly positive.

Virtually everyone in the treatment programs associated with the criminal justice system said this is something we need to get moving on, even though it would be difficult to do much with the limited funding available.

We called a meeting to see if we could get agreement on general concepts. About 50 people attended from Public Health, the District Attorney's Office, and the Probation Department. There was virtual unanimity on all the broad issues, and the reasons to go

forward. There was clearly a need to have a more uniform way of dealing with people with mental health problems who are brought into the criminal justice system. All the criminal departments in the courts were handling mental health cases, but doing it in an improvised way.

It made more sense to encourage the person to get into treatment instead of sending them to jail. It made sense to create a team. The judge would develop expertise as would all the members of the team. It seemed worth doing, even if we were not assured of funding. Just at that time, SAMHSA put out money for starting up mental health courts. We still don't know if we will get that grant.

We had our first getting down to details meeting in October 2002. Our most recent meeting was Monday of this week. We held our very first session of the Court today, with about ten people.

Let me tell you what I think the court is going to look like, but all of this is on an ad hoc basis until we know if there will be money to support this.

Who's eligible for the court? This has to be agreed on by the two leading protagonists, the District Attorney, Terence Hallinan, and the Public Defender, Jeff Adachi. Either of them could veto such a court by not participating. We met with them at length, and they have agreed to throw their support behind the Court.

Who can come into this court? First, what criminal charges can be eligible? It looks like we have decided that both felonies and misdemeanors will be included. The only exclusion will be domestic violence or serious felonies or violent felonies, like rape and murder. But charges like burglary, auto theft, can come into the Mental Health Court.

Do they have to plead guilty? In many places they can not come into the court unless they plead guilty. This means if they don't succeed in the specialty court then the regular court can proceed with the conviction. It looks like our clients won't have to plead guilty to misdemeanors and lesser felonies. But they will have to for more serious felonies.

What about treatment suitability? People with a serious DSM-IV diagnosis would be eligible. No one would be ruled out for any particular diagnosis. We want to help the people most in need of help.

Who will be on the team? The District Attorney and the Public Defender will select the staff from their offices who are interested in this and willing to learn about mental illness and treatment plans. Probation already has a staff person in place. Someone from CJCJ, and Dede Rodriguez from Diversion. Jail Psychiatric Services will be on the team, and someone form CMHS. Those people will talk each day about who is in Mental Health Court that day.

Someone comes to Mental Health Court when anyone in the criminal justice system decides they are suitable. It might be a judge in another department who will make the referral. This is a treatment-based court vs. a punishment-based court.

Often there will be a report ordered from Jail Psychiatric Services. Mental Health Court will be explained. An assessment will be done by Jail Psychiatric Services to determine if the person is suitable for Mental Health Court. A treatment plan will be prepared. That will include the success criteria. The goal of the Mental Health Court is to assist the person in the treatment plan. Probably medication compliance will be part of it. There may be a residential treatment dimension. Most likely the client will be involved in a treatment program at Diversion. There are groups all day on substance abuse and life skills. There is a washer and dryer, plus meals, money management assistance—an array of programs and services designed to assist the clientele of the Court.

The Court will meet once a week, and clients will come back once a week to get to know the judge. The clients speak directly with the judge, who will try to engage the client in conversation to learn about him or her and to encourage the person to be involved in treatment. To praise when things are going well, to dole out sanctions when things are not going well. There may be admonishment, jail time, sheriff's time, cleaning up streets, writing essays, community service, etc. We have incentives for people who are doing well. We give them gifts, from chocolate bars to T-shirts to bath supplies. The ultimate carrot is the dismissal of the charges.

We expect that the typical misdemeanants will come to Mental Health Court for probably six months. For people with felony charges, facing potentially going to state prison, there probably will be no problem having the Court in their lives for 1-2 years or maybe even as long as 3 years.

There will be monitoring of the treatment plan by the Mental Health Court team members. Those who succeed will have graduations. In Drug Court these are very moving events. Last graduation, we had the Chief Justice of the California Supreme Court. And we've had figures from entertainment. But the best speakers are always the clients themselves. I encourage all of you to come to Drug Court graduations, and when we have them, to Mental Health Court graduations. We are in the early stages of this. We will continue the planning process. We encourage all of you to get involved in the planning process. This is a community court.

Mr. Leubkeman: I was curious what types of offenses you are contemplating will qualify. Judge Kahn: Initially it will be non-drug charges, because we have so many drug treatment programs through the criminal justice system, with mental health components. We'll see moderate to modest violence cases. It will include the whole array of theft offenses from burglary to petty theft to robbery to stealing automobiles Probably it will include what people refer to as quality of life crimes, such as camping, urinating in public, the crimes at the very lowest end of the criminal justice system, and which probably capture a disproportionate number of people with mental health issues. The problem with including them is that the punishment is modest, so there isn't as great a stick.

We've learned from Drug Court that the more likely people are facing incarceration, the greater their involvement in the program. Drug courts have shown, that people change, not just when they are "ready". Forced treatment, with criminal sanctions pending, is more likely to engage them in treatment and they are more likely to be successful than those who walk in off the streets to a public health facility and ask for help.

Ms. Walker: Is it anticipated that the offenders will have any say in developing the program that they must follow? Judge Kahn: Yes. It won't work unless that happens. That's true across the board in any kind of treatment. On the other hand, there are going to be people who purport to have expertise in the field and there may be or will be disagreement between clients and the treatment providers, and it may be the provider's view that prevails over the clients view.

Mr. Stinson: How will medication fit in? If they don't want to take mediation, will they be able to not take it. Judge Kahn: Probably not. If it is determined that medication seems necessary, then there will need to be medication compliance, not necessarily right away, but within a month or two.

Ms. Walker: If that person felt the medication wasn't right, would he be able to apply for a Riese Hearing? Ms. Leung: A Riese hearing is if a patient is being held on an involuntary basis in a hospital setting and refuses medication, then the hospital and doctor request from the court the right to force the client to take medication.

Judge Kahn: That will not apply to these courts. At first blush this may sound very totalitarian. But this is a voluntary court. Once you chose to walk into this court, and informed consent is very important issue, people will have bought into the concept that they will have to comply with their treatment plan, into which they will have input, but their civil rights have been suspended. The person has two choices, 1) to comply with the treatment program, which may or may not include medication, or a residential program, or 2) they can leave the Court. The defense attorney in this court is never advocating for a due process hearing.

Dr. Moses: Do you have a revolving door? Judge Kahn: I'm assuming that like Drug Court, you will have a lot of people fail out of the Court and then come back into the Court. There may be a view that after a certain number of times of revolving, given the limited resources of the courts, they may not let a person back in after 3 or 4 times in the Court.

The Court meets Wednesday afternoons. It's open to public like any court. The courts throughout California are pushing for more treatment based programs. Our Chief Justice is very supportive of this. But it won't get going in large measure until there is private funding and government funding.

Drug Court now receives $2 million in cash, and even more than that in treatment resources, and we have to show data in accord with rigorous criteria, and none of that has been done for mental health.

Dr. Moses: How do you decide if someone is malingering? Judge Kahn: I can't tell, so we will look to those who do psychological assessments.

Mr. Dorsey: What are the consequences of not making it through the court? Judge Kahn: The client will have to face the charges that are against them. Any time they have been incarcerated would be a credit. But it would be the decision of the regular criminal justice proceedings.

Mr. Wise: With this just being brand new, does this Court become immediately available to any inmate currently in jail serving time and receiving psychiatric services? Judge Kahn: Yes. As long as you are in the criminal justice system now in any way. Mr. Wise: Does this diminish the number of people Jail Psychiatric Services will work with? Judge Kahn: The reality is we're only dealing with a small number of people compared to the number Jail Psychiatric Services deals with, and they will still be dealing with these people. If anything, Jail Psych's role will increase.

Ms. Brooke: Isn't calling this Behavioral Health Court a little confusing? Judge Kahn: It's very confusing. It's my hope that this will be a successful court with mental health clients, and ultimately mental health and drug court will merge and we will have 2-3 judges. And it will be one unified court because people are unified people and have both mental health and substance abuse issues.

Mr. Shipley: I've been a consumer advocate in San Francisco for almost 21 years. So this is a strange partnership between DPH, criminal justice, and the state. If that's the case, the mission statement of State Department of Mental Health is to provide voluntary services to the mentally ill of California as much as possible rather than forced treatment. We know by empirical studies that force does not work. It may work as far as drug offenders and other criminals, but not with mental illness, because most of them will not comply if they get written up on a ticket. They won't follow through. That's one of the reasons we have a lot of them on the street. Forced treatment and coerced treatment does not work.

Judge Kahn: That may be, but preliminary data shows that Mental Health Courts have been successful in engaging people into treatment. It's really a combination of both voluntary and involuntary, because you've agreed to be part of the Court, but then you have to comply.

Mr. Kalman: The RAND study says the research is not conclusive. There is no evidence whether the Court will work or not. Other factors are involved, like the community infrastructure to support this. Everything is related to money. Can someone assure that if the court is mandating treatment that the money will be there?

Judge Kahn: No, it's a partnership. The Department of Public Health will control the resources and hopefully they will control them in a way to support the Court. Barbara Garcia is very supportive of the Mental Health Court to date.

3.0 DIRECTORS REPORTS

3.1 Report from the Director of Community Mental Health Services

Ms. Wang: I'm reporting for Bob Cabaj, Director of Community Behavioral Health Services, who is at a meeting in Sacramento tonight.

Budget Update. The FY03-04 Budget Process has begun. The Mayor's Office is projecting a shortfall of up to $170 million in FY03-04. To close the budget gap in both FY02-03 and FY03-04, all City departments, including the Department of Public Health (DPH), are required to submit a three percent General Fund reduction plan.

Additionally, in FY03-04, DPH must absorb labor cost increases. The majority of these increases are not related to salaries. Currently, the Mayor's Office is projecting flat salaries for the majority of civil service personnel in FY03-04. Finally, each Department must prepare a five percent General Fund reduction contingency plan. The contingency plan will be used by the Mayor's Office if they are unable to balance the budget. In FY02-03, the Department's were required to prepare a 10 percent contingency plan. The majority of the items were not implemented. The Department is currently preparing a plan to meet the Mayor's requirements.

Jo Ruffin. Jo Ruffin is retiring from the Department of Public Health after 36 years of dedicated service. Jo has most recently been the Director of Community Mental Health Services for seven years. A celebration of her career is scheduled for January 16, 2002 at 6:00 PM in the War Memorial and Performing Arts Center at 401 Van Ness in the 2nd Floor Green Room. An excellent summary of Jo's career appeared in the Winter Issue 2002-2003 edition of the San Francisco Mental Health Plan Provider Newsletter and the January 4, 2003 edition of The Independent.

Foster Care Mental Health Program Conducts Harm Reduction Focus Groups. The Foster Care Mental Health Program conducted two private provider focus groups to discuss the implications of the harm reduction policy on conducting psychological assessments with dually diagnosed clients. These meetings provided a forum for psychologists to discuss specific issues related to this topic. The forum also acted as a way to introduce and discuss the harm reduction policy as it related to DPH, DHS and the dependency court. The Focus Groups were well attended and yielded a lively discussion of many important issues and ideas. The Foster Care Mental Health Program will incorporate these ideas as we develop specific testing guidelines. For further information please contact Dr. Audrey Rosenberg @ (415) 970-3853.

Behavioral Health Integration Planning is Underway. Thirteen Behavioral Health Focus Groups have met. Ongoing planning is being done by a number of committees (i.e., advisory boards, budget & operations, client relations, clinical services, cultural competence, placement, provider relations, quality management, research & evaluation, revenue & billing, information systems). A report with recommendations will be completed by March 2003 for review by the Health Commission.

Request for Qualification to be Issued for Many Contracted Services. San Francisco's Administrative Code, Chapter 21.1, requires a competitive solicitation for the selection of providers or vendors for services. The maximum duration for the award of services is 10 years for locally funded services and 4 years for Federally funded services. As a result of this requirement, RFQs for a number of mental health and substance abuse services will be issued in January 2003.

Dr. Moses: I'm glad the Mayor is not going for a 10% cut like he did last year. If you must cut, I suggest not to cut consumer programs.

Dr. Del Zotto: The youth services being cut, are they in Children's Services?

Ms. Wang: Last year the Children's System of Care in San Francisco had a million dollars in funding and was cut by almost half. That will continue in the coming fiscal year. We're waiting to see what else the State will be cutting.

Mr. Stinson: One of the priorities we'll be voting on tonight is the integration of mental health and substance abuse services into Community Behavioral Health Services. Could you frame the issue for us?

Ms. Wang: There are 4,000 clients who are known both to Community Mental Health Services and Community Substance Abuse Services. It was a surprise to find this out, since we had never searched our databases for the commonality. For our mental health clients, often the substance abuse diagnosis is under-reported. Historically that's in large part due to funding sources and the requirements for eligibility. In order to make sure you don't have services being disallowed, you have to have certain diagnoses.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: The fourth Police Crisis Intervention Training is taking place next week. Augusta, Idell, and Kate are in acting roles again. Carol is a panelist. Mickey and Mike are going to be on the panel. Anyone who wants to participate let me know. You're all invited to graduation ceremony.

4.0 MENTAL HEALTH BOARD COMMITTEES
4.1 Report of the Chair of the Board and Executive Committee
Mr. Stinson: I think we had a fantastic retreat on December 7th. I felt it was incredibly productive to be able to talk about the issues which are important to us and to get to know each other better. This evening we're going to officially adopt and flesh them out. The three priorities being put forward for 2003 are: 1. Advocacy for the mental health budget. 2. Planning for integration. 3. Care Not Cash.

Dr. Moses: #1 is something we usually do anyway. I would suggest making Priority #3 into Priority #1. Dr. Del Zotto: I second that. Mr. Stinson: At the Retreat we talked about what percentage of the 2,700 people affected by Prop N are mentally ill.

Mr. Martin: My understanding is that it is people who have been triaged at DHS, and there are no signs indicating that they would be channeled into the SSIP part of the program. Dealing with the welfare system is an environmental factor that might produce illness in any number of us.

Ms. Brooke: Can I make the suggestion that we monitor Prop N's impact on mentally-ill recipients? I'd urge the Board to make the 24/7 Drop-in Center and Mobile Crisis a priority for the sake of not losing the momentum from last year. There's not much more to do, but if it is listed as a priority, that will help move those issues forward.

Mr. Martin: I'm very much involved in the 24/7 Drop-in Center. It's very much a priority in my work. I don't see why the Board would have to take it on as a primary obligation. But I would certainly enjoy it if the board would support our efforts to make it happen. It's a very real need and I think it is something that's doable.

Ms. Walker: I would agree with what you both have said. If we put it in the Annual Report and wherever else, we keep reminding people of it over and over again.

RESOLUTION (MHB-2003-03)
BE IT RESOLVED, that the Mental Health Board, in concordance with its state-mandated duties and contractual duties, will focus priority attention and action on the following four issues during 2003:

1. **Advocacy for the mental health budget for 2002/03 and 2003/04.**
2. **Participation in planning for integration into the new Community Behavioral Health Services.**
3. **Monitoring the implementation of Proposition N, "Care not Cash."**
4. **Increasing the hours of operation of Mobile Crisis to 24/7 and establishing a 24/7 Drop-in Center, and,**

BE IT FURTHER RESOLVED, that the Executive Committee of the Board may at any time make recommendations to the Board about altering or amending these priorities in response to new information, events, or crises, or in the case that any of the priorities is completed or becomes irrelevant. (Passed.)

5.0 NEW BUSINESS
Dr. Moses: I'd like to invite the director of the Mental Health Rehabilitation Facility to give us a presentation. Ms. Walker: If the Board wants to take any position on AB1421, I'd suggest we take it up in the February meeting. Ms. Knight: We talked about inviting Keith Hutchison back to talk about issues of children.

6.0 PUBLIC COMMENT
Mr. Wise: I wanted to let you know about the passing of Gordon Pooler in December. He was a consumer advocate for many years. He was Chair for two years of the Community Advisory Board of the Department of Psychiatry at SFGH. He stepped down a year ago. We still have not filled his shoes or will we ever fill his shoes. I wanted to let people know, especially those of you who might have known him. He was a charter member of CMHS Consumer Council.

Mr. Shipley: I'm on the Board of Spiritmenders, and wanted to let you know we will probably be forced to close as of February 1st because we do not have money anymore. Even though our numbers are pretty well down, we have 200 members on paper. We serve some homeless mentally ill who are on the fringes of the system or not part of the system at all. We have been operating for 16 years. Our membership is refusing a contract from CMHS. Private foundations will not fund us anymore. We've made appeals and unfortunately no one has come through.

There being no further business, the meeting was adjourned at 8:37 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, February 12, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 min)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of January 8, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 12, 2003, to the following members: Bridgett Brown

2.0 DISCUSSION: Closing of the Mental Health Rehabilitation Facility (MHRF) (15 min)

Brief presentation about the closing of the MHRF.

3.0 DIRECTORS REPORTS (25 min)

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (15 min)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The chair will report discussions and actions of Executive Committee.

5.0 PRESENTATION: **Implementation of Care Not Cash and its impact on mentally ill persons.** (45 min)

Staff of the Department of Human Services will present the plan for implementation of care not cash and the programs planned for mentally ill persons.
Jennifer Friedenbach, Coalition on Homelessness, will present concerns about the effect of care not cash on the homeless mentally ill.

6.0 NEW BUSINESS (10 minutes)

Suggestions for future agenda items or issues the Board might consider looking into.

7.0 PUBLIC COMMENT (10 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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SAN FRANCISCO MENTAL HEALTH BOARD

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MENTAL HEALTH BOARD
ATTACHMENT A
February 12, 2003

CONSENT CALENDAR
All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a PROPOSED RESOLUTION: **Be it resolved that the minutes of the Mental Health Board meeting of January 8, 2003, be approved as submitted.**

1.2.b PROPOSED RESOLUTION: **Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 12, 2003, to the following members: none.**

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DISCUSSION NOTES
Mental Health Board
Wednesday, February 12, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

PLEASE NOTE: A quorum of nine members was not present, therefore this was not an official meeting but a discussion. No votes were taken.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Augusta Del Zotto, Ph.D.; Carol Knight; Joel A. Luebkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Rose Chung for Supervisor Aaron Peskin; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bridgett Brown; Bob Douglas; Andrea Leung, L.C.S.W., A.C.S.W.; Idell Wilson; Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: none.

PRESENTERS:
Jennifer Friedenbach, Susbtance Abuse Mental Health Work Group, Coalition on Homelessness
Dariush Kayhan, Director of Housing and Homelessness, Department of Human Services.

OTHERS PRESENT: Linda Wang (Director of Adult Services, Community Mental Health Services); Carla Perez (ACCESS - Psychiatrist); Larry Bevan (MHRF); Doug McKirahan (MHRF); Philippa Ruttgaizer (MHRF); Piers MacKenzie (MHRF) Emeric Kalman; Mickey Shipley (San Francisco Network of Mental Health Clients); Mike Wise (Voices at Bay, San Francisco Network of Mental Health Clients); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

Discussion began at 6:36 p.m.

SAN FRANCISCO MENTAL HEALTH REHABILITATION FACILITY

Mr. Bevan: I was a psychiatric technician who worked at the Mental Health Rehabilitation Facility and just recently went to the MOST Team. I want to thank the Board for allowing us to come tonight to respond to some very disturbing news about

I want to explain why the service the MHRF provides is unique compared to other locked facilities. The MHRF is a 140-bed hospital which is part of San Francisco General Hospital. It was approved by a bond measure in 1985 so we could bring clients back from out-of-county facilities, so family members could be more involved in their treatment.

We're a sub-acute facility. Our clients can't function in the community yet, but don't need acute care. They come to us and we help them re-integrate back into the community. There are a tremendous number of family members who come to the MHRF who help us re-integrate clients back into the system. We have family members who could never get up to Napa State Hospital, or to Novato or Redwood City on their own. A lot of our residents are able to go out on pass to visit family members. But if they were in the out-of-county hospitals they couldn't do that.

Our residents are able to go visit facilities and spend time there and decide if they like it there or not, and be more involved in deciding their treatment plans. They couldn't do that from an out-of-county hospital.

Basically we provide them an opportunity for housing and to be in the community where they belong. We're able to do many more things than other facilities. We've even provided hospice services. People have been able to die with dignity in the presence of family members because of the MHRF. We had one client whose sister could visit every day when he was dying.

All of the staff here tonight have been with the MHRF since it opened. Many of us have been working in the field for 20 years.

Dr. Del Zotto: What can we do to help you? Mr. Bevan: We're encouraging the Health Commission to just say no. Just say no to the Mayor. Let the Mayor make the cuts. Let us go to him and hold him accountable. It's like he wants us to make a political decision so he will have cover. We think there shouldn't be cover. We're also looking at ways to increase revenue, and we are looking for ways to make things run more efficiently.

Dr. Moses: Is the MHRF going to stay? Mr. Bevan: They are going to redirect it. They will send 42 people out-of-county and turn the rest of the MHRF into a Board and Care residence.

Mr. Luebkeman: Are the other L Facilities state run? Mr. Bevan: No, they are private or nonprofit.

Mr. McKirahan: The acuity of our residents in the last three years has risen dramatically. We have a lot more staff injuries and resident-to-resident injuries. We're worried that there are many more than 42 people who need intensive treatment.

Mr. Warshauer. I'm here from Local 790. What can your Board do? If your Board is up to the task and willing to get involved in this issue, you can lobby behind the scenes, or pass a resolution encouraging the Health Commission to resist the proposed cuts by the DPH Director of Mental Health.

We think it is a question of priorities. We realize it is a difficult budget time, but it is a time when the priorities of the City need to be re-examined. We think it is critical that the mental health services of the City should not be targeted for these kinds of cuts. We think it is not fair to take advantage of people who need these services.

Dr. Moses: How about the leadership at MHRF? Is the leadership okay? What's going on there? Mr. Warshauer: That's a good question, an interesting question. As in any organization there is room for improvement. We are not holding the MHRF out as a perfect institution. We are willing to be involved in any effort to make the MHRF more efficient, including looking at the leadership. Our problem is that these cuts were made as *fait accompli*, without any input from us or the community. We'd like your group to have input. We do not think we should be throwing the baby out with the bath water.

Mr. Bevan: We think there are some areas of changes we could discuss, but right now, we're worried about being even open in 7 months.

Dr. Moses: I was there when we created the MHRF. We fought hard to get it, so we could bring our consumers home from out of county.

Member of the public: In our meeting with the Director of DPH, he made it clear that even if the money was found he'd still advocate for closing the MHRF. We want your help in making mental health a priority in DPH. It seems like mental health is a lower priority than medical services.

Mr. Howard: I am a neighbor of the General and a former member of the Consumer/Family Member Task Force when the concept for this facility was developed. If the City closes this facility, they won't be able to reopen it as something else, because one of the considerations for the money was that it be a rehabilitation facility. And more importantly, I see the staff when they are walking the clients to the neighborhood stores. I've heard a lot of bull over the years going back to Dukakis and Reagan, and I have seen little being done, except for this facility which is working hard to get people out of Market Street near Sixth Street and I see a lot of people out in the street. If you are going to close the MHRF more people will be out on the street.

Mr. McKenzie: I have a family member in the MHRF. Without the MHRF I don't know where our daughter would be today. She went into the hospital and then Ward 6B. Without the MHRF, I think she would have been a danger to herself. She receives marvelous attention at the MHRF and is well on her way to recovery and becoming a valuable and useful citizen. We go every day to see her. We take her out on passes every other day. It's a marvelous program. If you close MHRF, you're going to have an enormous number of people falling through the cracks. I'm merely one of many, many family members. I have an automobile, but many people don't. I think it would be a dreadful, dreadful step to close this marvelous facility.

Mr. Wise: Another angle is the salaries of the people working there. When this was dumped in your lap, is there any indication of what's going to happen to all the people who are employed by the MHRF? Is there any contingency plan?

Mr. Bevan: We were told by Dr. Katz that there are possibly some other places in the City some of us could go to. But there are classifications of positions of the MHRF that were made for the MHRF and don't occur any where else. When the MHRF reopens there are no guarantees for employing the current staff.

Mr. Warshauer: We prefer to focus at this point on maintaining the MHRF and want to see that the promise made to the voters who built it is kept. We feel more hopeful today, because we feel in this room there is a sympathetic group.

Mr. Luebkeman: What level of care will people get out of county? Mr. Bevan: I worked at Crestwood Modesto and it was a snake pit. They closed that facility. The staff there still wore nursing whites. They didn't take clients out on walks. Telecare brags that they have 75% staff annual turn over and that that's a good figure for the industry.

Ms. Walker: What's your turnover? Mr. Bevan: I'd say that we have 60% of the staff we started with six years ago.

Mr. Warshauer: That is one of the priceless resources that is there. The staff collectively have literally hundreds of years of experience in dealing with these clients. You cannot put Humpty Dumpty together again. Can you imagine if this staff is dispersed? It is not a path you can go down and then reverse course.

Dr. Moses: Have you talked with Dr. Katz or Dr. Cabaj? Mr. Warshauer: Some of us met with Dr. Katz. We have initiated a dialogue. But that was our initiation of the dialogue. We have had to scramble to get ourselves together to be able to defend this institution. We are assembling e-mail lists and working to get our case out to the public.

DIRECTOR'S REPORT

Ms. Wang distributed the written Director's Report:

Budget Update. The Mayor's Office is projecting a shortfall of $350 million in FY03-04. To close the budget gap, the Department of Public Health (DPH) is required to submit a $17.5 million General Fund reduction plan. Additionally, in FY03-04, DPH must absorb $20 million in unavoidable increases. To address this shortfall the Department used the strategic plan to guide its decisions. As a result, the Department proposed $11.7 million in revenue increases, $5.0 million in Administration reductions, $7.7 million in service reductions and an $ 8.1 million reduction to the Mental Health Rehabilitation Facility, which will be reprogrammed to become a Residential Care Facility. To enable the Department to obtain $2.0 million in savings, which will be used to offset the shortfall in FY 03-04, it has implemented a hiring freeze for the remainder of this Fiscal Year.

Medication Adherence Pilot. Quality Management has completed a full year evaluation of an Eli Lilly funded medication adherence pilot based at Westside Community Mental Health. A cohort of twenty-six medication non-compliant clients were enrolled in pilot beginning in the Fall of 2001. The results thus far seem promising. Eighty percent of clients have been retained in the program; the overall mean adherence to medications exceeded 90%; acute service use has declined by 60 to 90%; client functioning has shown distinct improvement and client satisfaction with the program is very high. The pilot has another six months before completion.

L-Facility Discharge and Community Tenure Evaluation. Quality Management has commenced the second phase of a longitudinal evaluation of the outcome of care for L-facility (IMD) discharged clients. This evaluation includes a cohort of clients who were discharged from L-facilities in 1997 and 1998. The findings of the first phase were previously reported. In essence, the evaluation identified an array of factors, e.g., housing, substance abuse, physical health, social support, client demographics and service use patterns that contribute to community success. Staff will continue to monitor and track client status including housing, vocational efforts, clinical indicators, community functioning, service utilization, physical health status and recidivism.

Behavioral Health Integration. Planning for the integration of CMHS and CSAS into Community Behavioral Health Services is moving forward. Thirteen focus groups have been convened to solicit community input into the planning process. A final report by the consultants has been submitted.

Residential Care Network. The Mental Health Residential Care Network Management Team provides placement and support services to licensed residential care facilities (RCFs) that house over 600 of our mental health clients. RCFs provide a supportive, stable and caring environment for these clients who need medication monitoring. A collaborative team, including an in-house internist, a visiting psychiatrist, and a Community Behavioral Health case manager/clinician, provides comprehensive care plans. These community placements provide medical and psychiatric stability for clients in the least restrictive setting, while promoting recovery, self-sufficiency, and quality of life.

Of the 112 clients placed into RCFs in the first 6 months of fiscal year 2002/03, 46% were referred by the Mental Health Rehabilitation Facility, SFGH inpatient units, private inpatient hospitals, and locked facilities. Residential care placement presents a humane, clinically appropriate, and fiscally responsible solution to housing mental health clients who would otherwise be at risk of frequent hospitalizations or institutionalization in more costly long-term locked facilities (IMDs). These placements are significant fiscally and clinically, given the low rates of recidivism (psychiatric emergency and inpatient admissions) for mental health clients discharged to permanent supported housing in the community.

Advanced Access. At a meeting of outpatient clinic directors and clinic medical directors at the end of January 2003, 12 out of 15 clinics reported that they are now able to see new individuals for intake evaluations and medication evaluations within 24-48 hours of receiving the request. Of the remaining reporting, the longest waits were up to two weeks for an intake evaluation and medication evaluation. Factors impacting access are significant vacancies, difficulty recruiting and limited capacity in certain languages. Even so, access for new clients has significantly improved from two years ago, when three quarters of the outpatient clinics were either closed to new referrals or had waits of up to two months. Clinics are collecting demand and delay data in order to make management decisions on both the clinic level and system level. CMHS is exploring various strategies to make best use of limited resources in the clinics.

Ms. Wang: You've just heard that the MHRF is scheduled for closure, and then re-licensure. The MHRF is licensed for 147 beds, and usually has a census of 140. What I've heard about changing the MHRF to a residential care facility is that the City would own the license, but how it would operate is not clear at this point. In the MHRF building, there is an adolescent treatment facility. That would not be touched.

Mr. Luebkeman: What are the demographics of the clients in the MHRF? What are the issues they are dealing with? Ms. Wang: All the current clients were transferred from acute inpatient hospitals, or transferred from out of county, like Napa, or Crestwood Vallejo, or Canyon Manor. They are people with severe depression, psychosis, or schizophrenia, as well as people who are not able to handle independent living or even supported living.

Mr. Luebkeman: Do they have their own rooms? Ms. Wang: The rooms are shared. Most clients are on conservatorship, so they are there involuntarily.

That's one cut. Other cuts are in relation to day treatment. The day treatments of RAMS and Thunderseed are being cut. One of the two FSA geriatric day treatment programs will be eliminated. The Conard Residential Treatment program will be cut from 24 beds to 16 beds, so they can bill for federal dollars. There will be $200,000 cut from the provider network. Right now our clinics are able to manage because a number of clients can be seen by private practitioners in a private office.

The Department has also been asked to develop a contingency plan. The contingency plan would eliminate all day treatment programs, including the Clubhouse that serves the Tenderloin, the other FSA geriatric day treatment, Rypins day treatment, Chinatown North Beach, Westside Lodge, and Clay Street Day Treatment.

Mr. Stinson: What's the total contingency? Ms. Wang: For mental health, another $2.5 million. Programatically that's about $5 million, because we'll lose the federal match.

Mr. Luebkeman: Do you have a dollar amount for the proposed cuts? What percentage of the overall mental health budget does it represent? Ms. Wang: The total mental health budget, including Napa State Hospital and the L-facilities, and residential treatment, is probably approaching $150 million.

Dr. Moses: What's going to happen to the clients in day treatment? Ms. Wang: Those clients will have to be served. They won't disappear. There are three options: outpatient care, medications, and possibly some groups, or case management and socialization services. But all these are in limited supply.

Dr. Moses: What will happen to the MHRF building? Ms. Wang: It will be turned into a Board and Care facility.

Ms. Walker: Are you short on case managers right now? Ms. Wang: Yes, that's right.

Mr. Kalman: I had occasion to visit the MHRF. It is a wonderful facility. I just wondered why this has to be given up for some profit residential care. Also, is this

Mr. Kalman: I had occasion to visit the MHRF. It is a wonderful facility. I just wondered why this has to be given up for some profit residential care. Also, is this because we have to transfer some people from Laguna Honda to put them someplace when they redevelop Laguna Honda?

Ms. Wang: The reason for this change is primarily a fiscal reason. Adults who are being treated are not eligible for federal dollars if you are an adult in an IMD. There is a federal restriction for adults. You cannot access federal dollars in these large treatment facilities. So they are totally supported by local dollars and state realignment money. And with both the state and the city having this major fiscal crisis, it becomes a prime target for a budget cut proposal.

Mr. Luebkeman: Is our congressional delegation able to be of any help to get those regulations changed? Ms. Wang: This regulation is due partly to the feds not wanting state hospitals to be covered. They consider hospitalization to be a state responsibility.

Mr. Wise: If the MHRF becomes converted to a giant Board and Care home, where is that money going to come from? Ms. Wang: The Board and Care license is very different than a rehabilitation facility license.

Dr. Del Zotto: As people are going to these privatized entities, would community oversight be more limited? Ms. Wang: If it's a contract with us, then we have jurisdiction over it.

PROPOSITION N: CARE NOT CASH

Mr. Stinson: We're fortunate this evening to have two perspectives on this issue:

Dariush Kayhan is the Director of Housing and Homelessness at the Department of Human Services. In our audience also is George Smith, Director of the Mayor's Office of Homelessness.

Jennifer Friedenbach is the Coordinator of the Mental Health Substance Abuse Work Group of the Coalition on Homelessness.

Mr. Kayhan: We are charged with implementing Proposition N, Care Not Cash, starting July 1, 2003. Proposition N will only impact 2,400 to 2,900 people.

Mr. Kayhan then offered a PowerPoint presentation as follows:

WHAT DOES PROP N DO?

- Requires DHS to provide housing and food instead of a full cash grant to homeless individuals on the county's public assistance program (County Adult Assistance Program - CAPP)
- Redirects county annual general fund appropriation from aid payments to services ($13.9 million).
- Establishes a "baseline" funding level of redirected aid payments to homeless services.
- If DHS cannot provide the housing/shelter and food, clients receive full cash grant.

- Does NOT reduce the cash grant for housed CAAP recipients.
- Homeless senior citizens are not disproportionately affected (less than 6 on CAAP)
- Is NOT a Voucher System.
- Will NOT "solve" homelessness

DHS' GOAL FOR PROP N IMPLEMENTATION
To reduce homelessness and improve the health and welfare of homeless indigent adults receiving cash assistance through enhanced services and expanded housing opportunities.

DHS PRINCIPLES FOR PROP N IMPLEMENTATION
- People are better served in shelter/housing than on street.
- Services should be tailored to meet individual needs.
- Length of time in shelters should be minimized.
- Affordable housing options should be expanded.

DHS EXPECTATIONS FOR PROP N IMPLEMENTATION
- Decrease the number of homeless individuals on the County Adult Assistance Program (CAAP)
- Expand affordable housing units and services for CAAP clients
- Increase accountability throughout the public assistance delivery system for homeless indigent single adults.

HOW WILL DHS IMPLEMENT PROP N?
- Expansion of Permanent Housing for Single Adults
- Increase services and link services to permanent housing (treatment, case management, money management, employment, SSI Advocacy)
- Implement Homeless Management Information System (with finger-imaging)
- Minimal expansion of shelter beds and phase out of intensive service provision in shelters.

The three steps of the program are:

1. Enrollment.
Everyone coming into the current emergency shelter system would come in through the Homeless Resource Center. Finger imaging will be done with them and a digital photograph will be taken as part of the Homeless Management Information System. People would come in through 1235 Mission or Resource Centers throughout the city.

2. Assessment.
We would get to know people better and get to know their special needs. There would be a 1-2 week assessment within a shelter, including interviews and observation. We are developing the assessment tool.

3. Transition
Then there would be a transition to supported housing, including special needs housing, leased housing, health department programs, etc.

We want to provide enhanced services. We're looking for input into this. Of course budget cuts are being implemented, which means cutting services that CAAP clients have accessed. We're looking at supported housing. Also we're looking at SSI advocacy to increase income.

We are establishing a Prop N Service Advisory Committee. Helynna Brooke, has been a strong advocate in trying to get the MHB a seat on that committee. That committee is for direct providers. The Department is setting up a Community Advisory Committee.

We hope to have Prop N become a regular item on the DHS Commission agenda. The Board of Supervisors is going to hold monthly meetings regarding this program. The Service Advisory Committee has two sub-committees: one on services, the other on housing.

Ms Friedenbach: As you know, people with mental illness are disproportionately represented in poverty. Income assistance has been a cornerstone poverty abatement program in countries all over the world to keep people's needs met. Prop N is cutting assistance to the poorest of the poor.

It's the political context that this is happening in that makes things scary. There is a mayoral race coming up. Proposition N happened in the context of that race in order to a get a politician's face out. It was something responsive to polls.

There is a short time to make this program successful. This could easily be done by making it not a very fun program so everyone gets off it. It could displace people from other homeless programs. The entire homeless system is being completely changed around due to a ballot measure that was passed due to a mayoral election.

There are a lot of people with mental illness who are going to be affected by this. They are the people who are going to be hurt by this the most.

There are people who have a severe mental illness who are on SSI or have no money who will be negatively impacted because the City is talking about changing the whole homeless system around to fit into this Prop N system.

It starts with the shelters. The only place DHS realizes a savings is within the shelter. But the shelters are not great places for people with mental illness, because it's congregate living, often in large open spaces. Someone with mental illness may be disturbing other clients all night by talking loudly and then will get a lot of negative feedback. Many cannot deal with congregate living.

Everyone in this proposal is being funneled through the shelter. If they don't take the shelter they lose their benefits. This is something to watch and try to get exemptions in there. If you are noncompliant in the shelter system, you can get kicked out and you lose your public benefits. This is a really great concern. This could possibly be corrected.

With regard to housing in the hotels, some people because of their disabilities are not appropriate. If they are yelling all night, they get evicted and then lose their benefits. This is an unsafe situation for people with mental illness.

There is a big question mark about people being able to move into housing on their own. If you are in a shelter system right now, you can save up money to move into a place. But now they won't be able to do that because the money will be taken out of their check. How will these clients be able to move into a place? People living in illegal places, based on cash economy, have no rent receipt, so they won't be able to get their benefits.

Most of the housing is not permanent. Most housing is in Single Room Occupancy hotels. People don't have their own bathroom or kitchen facilities. Currently housing provided through the Department of human Services requires a subsidy. It costs between $600 and $900 per month (including the $300 paid in rent) to provide housing under the Master Lease. That is equivalent to at least two people's checks. Where is that extra money coming from?

If people have pets there's a problem. A lot of people on the street have companions, which helps with their mental illness. Will pets be allowed in the SRO hotels?

Finger imaging is going to cost a lot of money, probably $100,000. And this is mandatory, so if you refuse finger imaging, you don't get access to shelter beds. This is really going to impact people with mental illnesses in a big way. And even if it didn't, what's the advantage of finger imaging? There hasn't been a strong case made. They could do other things.

Connected to this is the assessment piece. It's a very different situation when people share information in the mental health system and substance abuse system, which protect people's confidentiality. People with mental illness are very concerned about this. Confidentiality is basically being thrown out. There's not the same culture of concern for privacy in the Department of Human Services, but they are now getting into health issues.

This whole system is not an engaging approach for people with mental health issues. They are already so disengaged and disenfranchised. This is going to add a whole other layer. Having services in the shelter is no longer going to be helpful, because the front end requirements are going to be keeping people with mental illness out.

We also have a concern about displacement. We don't cut Prop N, but we're cutting everything else. This puts us at serious jeopardy of displacing non-Prop N recipients. They are transferring programs from DPH to DHS for this very reason. Why does DHS want these programs? Because they want access to them for Prop N. A Man's Place shelter is being transferred to DHS. Also the Redwood Center.

Public Health has a financial incentive to get people into treatment. DHS doesn't have that incentive. Some people say the eligibility workers job is to keep people off public assistance, and then when someone has benefits, the idea is to get them off. We've

Public Health has a financial incentive to get people into treatment. DHS doesn't have that incentive. Some people say the eligibility workers job is to keep people off public assistance, and then when someone has benefits, the idea is to get them off. We've developed a diverse homeless shelter system to meet the needs of different people. A Man's Place is low threshold. It's different than the other shelters.

It's important to evaluate Prop N in terms of reduction of overall homelessness instead of just in reduction of CAAP recipients. There are lots of administrative costs. Lots of high-level DHS policy makers are spending quite a lot of time on this.

The provider meetings are going on now. They are a little frustrating. No votes are taken. So it's a little awkward. Just a discussion thing. There is no client representation on it. The Board of Supervisors is probably going to be where a lot of the stuff can be monitored.

We can work to reduce some of the harm, but we can't reduce all the harm.

Finger imaging is not part of Prop N. They are just taking the opportunity to do something they want to do.

Mr. Kayhan: I'd like to respond:

1. Reasonable accommodations will be made for mental health clients. The Department of Human Services has understanding of this.

2. People don't need a rent receipt to prove housing. An informal arrangement can be made.

3. The Redwood Center is not being transferred to the DHS. There is a plan to transfer the Man's Place, but that is less about changing the program design than getting clients off the streets. We'd rather have the clients come indoors.

Ms. Friedenbach: The Redwood Center is written into the DPH budget as being transferred to DHS. Maybe that's a mistake. With regard to rent receipts, illegal landlords won't want to write a letter. People are not given accommodations in DHS right now. Dar's boss, Jim Buick, is very clear about doing finger printing. We would want to push for making accommodations about the finger imaging.

Mr. Luebkeman: What about the lawsuit? Will Prop N be implemented on July 1? Could Prop N help mitigate the budget cuts?

Mr. Kayhan: We're moving forward on implementation while the City Attorney's Office is watching the lawsuit. If we are told to stop implementation, we will. We can't supplant services that are cut. This money is for new services and new housing. I recognize this is a difficult time, but we can't supplant those cuts.

Mr. Luebkeman: Could DPH turn over services to DHS for funding?
Mr. Kayhan: That sounds very much like supplanting.

Dr. Moses: Is there an independent committee?
Mr. Kayhan: We have set up an Advisory Committee, though the Board of Supervisors will have input and also DPH.

Dr. Moses: Since this is the will of the people of San Francisco, is there anyway to support this rather than opposing it?
Ms Friendenbach: My feeling is that the electoral process is flawed. Over $1 million was spent to cut the income of the poorest San Franciscans, so I don't have any problems opposing this. But there is a lot they can do to reduce the harm. They won't have enough services to begin with. So they could make this voluntary. If this is as beneficial to people as DHS thinks, then you would expect to have people coming forward to volunteer for it.

There's a lot that can be done around ADA protection to make sure that people who refuse shelters due to safety concerns are not denied benefits. A lot can be done around money management programs for people who are addicted, which is what the voters were concerned about. So yes, there are a lot of things that can be done.

Ms. Walker: If I read the draft of your implementation plan right, the expectations are to decrease homelessness, and to increase housing and to improve the accounting systems. Can you do that on the $14 million budget that you've got.
Mr. Kayhan: We think we can.

Mr. Stinson: With regard to the assessment step, the people who will be doing the assessment of the mental health issues, what are their qualifications, what are the tools, and what happens if there is a positive outcome?

Mr. Kayhan: We are actually looking for a lot of input on the assessment and the tools. We've been talking with DPH about that. The assessment wouldn't happen until people came into the shelter. It's recommended that we use a slow process of assessment instead of doing it all at once up front. We are trying to balance this out to make sure that the lion's share of our money goes to housing.

Mr. Stinson: The work Maria Martinez of DPH has done with CalWorks is somewhat analogous to this.

Ms. Knight: It seems like the housing you're referring to is the residential hotels. My concern with that kind of housing is that some of the residential hotels are in more deplorable condition than some of the shelters. So you have mentally ill clients who would have no choice but to pay for these hotels. You'd be using City money to put clients in hotels that are deplorable. Some clients feel safer on streets than in shelters or hotels.

Mr. Kayhan: Many people use their GA assistance check to pay for rooms in private hotels that are deplorable. We would only enter into an agreement with an SRO hotel if they abate all code problems. We look for the owner to do some upgrades as well. Here is a stock of housing that has been used by poor people in the past. It's one of the

they abate all code problems. We look for the owner to do some upgrades as well. Here is a stock of housing that has been used by poor people in the past. It's one of the housing stocks that is affordable. It could be improved and provided with supported housing.

Ms. Friendenbach: There should be a differentiation between what MHB thinks of as supported housing, like Conard, and the Master Lease hotel. You are leasing the rooms, sometimes the conditions improve slightly. But it's a time-limited lease. It's permanent housing in the sense that people have tenant rights, but the City doesn't have control over it long term. This shouldn't be the primary housing endeavor, though it could be part of the mix.

There have been some pretty substantial displacement issues. A lot of our folks who try to get into Master-Lease housing have been denied. All of our staff at the Coalition who have tried to get into Master-Lease hotels have been denied. The advantage is that it does lock in the rent and stop the merry-go-round rooms where people have to move every 27 days.

Mr. Luebkeman: After the assessment process is completed, how will the identification card work?

Mr. Kayhan: We haven't talked about the ID card. The client will just put their finger on a reader, and then they won't have to carry an ID card.

Mr. Shipley: It's interesting that somebody who's probably never been homeless came up with the plan. Speaking as someone who was formerly homeless, drug-addicted, and with mental illness, and has some knowledge of people who live on the streets, and works with people who are on the fringes of the system, most of them have been traumatized and abused by the system. What makes you think that they will participate in any of this system? Many of them have gone through the criminal justice system and hate being finger printed and hate authority and hate any control in their lives. If you have the system tell them how to do it, they are not going to comply.

Mr. Wise: I think this displacement issue Jenny brings up will be a probability not just a possibility. People will be having a lot of questions asked, and a lot of hoops to jump through. I'm concerned about the people now in SROs being displaced. I think of San Francisco as having a finite amount of housing. You'll be displacing people. You said there are plans for new housing.

Mr. Kayhan: We don't displace people. We've developed 6 Master-Lease hotels. We immediately sign people up with a lease so they have tenants rights. This stops the merry-go-round. We bring the rents down. It's run properly. There's a 24-hour desk clerk and proper janitorial services. There are many, many units off line that are not being used. I don't see what's wrong with capturing these buildings and making them affordable and bringing in support services. If these buildings come up for sale, we'll buy them. It's not displacement.

PUBLIC COMMENT
No comments were made by the public.

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San Francisco, CA 94103
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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, March 12, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 min)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of January 8, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 12, 2003, to the following members: Bridgett Brown, Dennis Yun, Andrea Leung, and Idell Wilson

1.2.c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of March 12, 2003, to the following members: Bridgett Brown

2.0 PRESENTATION: THE MENTAL HEALTH REHABILITATION FACILITY
Mozettia Henley, Director (35 min)

3.0 DIRECTORS REPORTS (30 min)

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (30 min)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.

4.1.a PROPOSED ACTION: Passing a resolution regarding the budget crisis facing San Francisco and the impact it will have on mental health services. (Attachment B)

5.0 NEW BUSINESS (10 minutes)

Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (10 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

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Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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MENTAL HEALTH BOARD
ATTACHMENT A
March 12, 2003

CONSENT CALENDAR
All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of January 8, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 12, 2003, to the following members: Bridgett Brown, Bob Douglas, Dennis Yun, Andrea Leung, and Idell Wilson

1.2.c PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of March 12, 2003, to the following members: Bridgett Brown

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MENTAL HEALTH BOARD
ATTACHMENT B
March 12, 2003

PROPOSED RESOLUTION (MHB-2003-xx): RESPONDING TO THE BUDGET CRISIS

WHEREAS, the City and County of San Francisco is facing a decline in revenue which in turn is threatening a severe cut in services; and

WHEREAS, these cuts mean a crucial loss of services for individuals in the short-term; and

WHEREAS, these cuts will cause the City to lose highly qualified and very experienced staff during a time when it is already difficult to recruit qualified staff due to the cost of living in our city; and whereas staff who are laid off may be lost to our system permanently; and

WHEREAS, any treatment sites and service facilities which have to be closed down during the current crisis, may be impossible to re-establish in a future year depending on the real estate market; and,

WHEREAS, with regard to mental health services, the Bronzan-McCorquodale Act of 1991 (Section 5600 and following in the State Welfare and Institutions Code) outlines a complete system of care as the most effective and cost-efficient way to provide services and mandates that Counties to the best of their ability provide a comprehensive system of services, and

WHEREAS, in San Francisco, Community Mental Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines, and whereas, cuts will fragment that system and damage its cost effectiveness strategies, and

WHEREAS, a severe cut will mean that many clients of the mental health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community; and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis with a comprehensive revenue strategy, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services, including the San Francisco Mental Health Rehabilitation Facility, so permanent damage is not done, and
to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured working citizens, and

BE IT FURTHER RESOLVED, in summary, that San Francisco be a role model and deliver a message to our nation about the importance of protecting our infrastructure and protecting all of our citizens, even, or especially, during a time of international crisis and danger, and that we not end up losing the very things we are seeking to defend.

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UNADOPTED MINUTES
Mental Health Board
Wednesday, March 12, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Augusta Del Zotto, Ph.D.; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Rose Chung for Supervisor Aaron Peskin; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Idell Wilson; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ON LEAVE: Bridgett Brown; Bob Douglas.

BOARD MEMBERS ABSENT:

PRESENTERS:
Mozettia Henley, Program Director, San Francisco Mental Health Rehabilitation Facility

OTHERS PRESENT: Linda Wang (Director of Adult Services, Community Mental Health Services); Peter J. Lindahl (United Behavioral Health); Mike Wise (Voices at Bay, San Francisco Network of Mental Health Clients); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 **CALL TO ORDER AND CONSENT CALENDAR**
The meeting was called to order at 6:34 p.m. by Ted Stinson, Chair.

RESOLUTION (MHB-2003-04): Be it resolved that the minutes of the Mental Health Board meeting of January 8, 2003, be approved as submitted.

RESOLUTION (MHB-2003-05): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of February 12, 2003, to the following members: Bridgett Brown, Bob Douglas, Dennis Yun, Andrea Leung, and Idell Wilson

RESOLUTION (MHB-2003-05): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of March 12, 2003, to the following members: Bridgett Brown. (Passed unanimously.)

2.0 PRESENTATION: MENTAL HEALTH REHABILITATION FACILITY

At our last Board meeting we had a number of people from the Mental Health Rehabilitation Facility (MHRF) who came to talk with us. This evening we're going to continue that discussion.

Dr. Henley: Thank you for inviting me to be here. I have so many feelings about the re-direction of the MHRF. When Helynna sent me the letter inviting me to the meeting, she included a list of questions that she thought the Board would be interested in. So I'll address those questions.

The first question is about my thoughts about the proposed changes to the MHRF. It's been interesting to us who are in the thick of it to hear from others outside what you believe that means. When people have heaerd about the reprogramming of the MHRF, they have assumed that there would not be a lot of changes. Staff came to your meeting last month to let you know there would be a change in the level of staffing, program, and level of care, and the current staff would mostly no longer be there. It would all be brand new.

First let me look at the cons: You know that the MHRF originally was to have reimbursement from Medicare/Medi-Cal. When we were about nine months into the program, we learned that we were not eligible for that funding, so that meant that we were funded entirely by the General Fund.

Now the Department of Public Health is being instructed to cut its budget. Just yesterday there was an instruction to reduce our budgets even further.

If this hadn't happened so quickly, we could have been very thoughtful about the planning to reprogram the MHRF. We're going to think very carefully about how to utilize the budget we're left with.

The change will probably increase the number of out-of-county placements in long-term care facilities. As we start to think about re-programming the MHRF to turn it into a residential facility, we are evaluating people who are out of county who we might be able to bring to the MHRF just as we'll be evaluating people at the MHRF to see who might need to go out of county.

Many of the people who we will bring back to the county from long-term care are probably going to need more intensive services, and if there are to be additional cuts, then what?

Next I'd like to look at the pros: One of the problems we have had is that there have been about 30-35 people we can't place elsewhere, so people are staying with us much longer than they have to. Then instead of making progress, they regress. We have clients with very complex issues.

With all of the slashes and cuts, there will be some services available at the MHRF as opposed to closing it. And there will be places for people returning from out of county who need residential care.

If at the end of this process, we determine we need more long-term care beds than we have, could we do that? That's not answered yet.

What about the impact on acute services? For the past two years, we have been looking at patient flow issues, to decrease stays in acute psychiatry, and we've done a very good job. But now, how will these changes impact acute care and PES? We don't know that yet.

Can the reprogramming actually be effective as of July. The Request for Qualifications (RFQ) is about ready to go out. We're putting the documentation together to get re-licensure. This kind of process can take a year. So can we be ready for July? That's not answered yet.

Another unanswered question is how the assessments are going to be done. How will it be assured that people get what they need? I've brought along information on how we plan to do the assessments of clinical issues, risk factors, etc. We also plan to do a self-assessment with our clients, asking them where they think they are in terms of all the issues, so they can be involved in the planning.

We also want to be able to provide a plan for each client who will be transferred, which will go with them.

I came here in 1996 from Washington, D.C., and the reason I came is I was quitting a job back there, and I was watching the news one night, and there was Sandra Hernandez, Director of the San Francisco Public Health Department, talking about providing health care to illegal immigrants. And I said, that's where I want to go. I love the advocacy among the population of San Francisco.

The families of our clients at the MHRF had their first meeting to organize to let the Board of Supervisors know about how they feel about their family members being sent out of county, and there were over 25 families there.

About 30% of the people we discharge from the MHRF go home to family. That's a much larger percentage than most people think.

Next, let me look at staffing changes. If there is going to be a lower level of care, that means that there will be a lower level of staffing. We're assuming that there will be case managers and nursing assistants. There should be a nurse at least for 8 hours a day. There will also be a need for physician support, psychiatrist support, and nurse practitioner support.

There will be a greater opportunity for peer counselors, not that there aren't a lot of peer counselors now.

What would the contractor require? A minimum of high school graduation, the ability to write and implement a service plan, a medical assessment, and a mental status report.

Dr. Moses: I'm really disturbed about the direction in which the MHRF is going. I remember many years ago this particular Board advocated for the MHRF. I remember when it was opened. And the reason we did that was to be able to bring our clients back from out of county. And here we are in less than 10 years back at square one. That's really disturbing. And as you said, come July you don't really know what's going to happen. And that's disturbing too.

You have hard working staff, and I'm sure the morale is bad because they don't know what's going to happen to them. What's going to happen to the staff? What's going to happen to the leadership?

Dr. Henley: Starting July 1, something will continue. It may well be that the staff at the MHRF now will continue. We're not sure. But we may have a problem—where will we get the money to pay folks? Because this is happening so fast, we don't have time to get things into a neat package. I wish I could be more specific but at this point in time, I cannot. There is a process for Civil Service staff. They will perhaps be placed elsewhere in the city. But there is no assurance that everyone will be placed.

One of the things I'm proud of is how our clients are engaging in the advocacy process. The clients did it all. When I went around and talked with them about the fact that the MHRF might be closing, they said, "What can we do?" And then they stated to plan. It was marvellous. And our staff is advocating. This work is not just a job. I've been working in and around mental health since I was 19 years old, and I'm not a kid anymore, and it's because I love it.

Mr. Stinson: I'm trying to understand this $8 million number that is put forward by Dr. Katz. Is this a real number or is it an aspirational number? Where does this money come from? Dr. Henley: It's mostly a savings in labor costs.

Ms. Walker: Is mental health taking the brunt of the cuts in the Department of Public Health? Dr. Henley: The second round of cuts, called the contingency cuts, cut really, really deeply into mental health.

Ms. Walker: In the first round of cuts it looked like almost all the cuts were in mental health. Dr. Henely: It's a large proportion.

Ms. Walker: When Dr. Katz presented his budget, I heard the MHRF clients speak at the Health Commission meeting and they were marvellous.

Mr. Leubkeman: I didn't understand how this will help you place the 30-35 hard-to-place clients. Dr. Henley: I meant by that that we would have 147 new placements--because the MHRF beds will be redirected. So these 30-35 people will be able to stay where they are. Many of our clients have issues like diabetes or incontinence and so they are hard to place.

Dr. Moses: As you know, this Mental Health Board is active in terms of going to the Board of Supervisors. The fight is not over yet. What kind of ammunition can you give us so we can articulate our message to the Supervisors and the public? Are you reaching your objectives?

Dr. Henley: I feel like we gave birth to this facility and to the program. So it doesn't feel good to now think about losing it. I believe we exceeded the expections placed on us in a very short period of time. When we opened in 1996, mnay of the people who came to us from out of county had recovered enough to return to the community. There's a woman who came to us from out of county very disturbed, with lice and scabies. She is now living the community. I see her at the bus stop every morning. She is doing well. We help get people back into lower levels of care.

The current length of stay for our clients is 6-9 months. This is a big difference we have been able to create in a short period of time. The effective use of psychiatrists and newer neuroleptics can be complicated to manage, and we have the staff who can monitor people as they get used to the medications. This makes a big difference.

With regard to our vocational programs: The clients who work in the General Store are the most deteriorated, the sickest, not the wellest. They have to learn how to pay attention to their whole self, to bathe in the morning. Well tell them, Oh my God, look at those hands, do you think anyone is going to take change from you with your hands looking like that.

One of the people who testified at the Health Commission meeting, talked about the MHRF saving his life. He is on dialysis and is HIV positive. He was able to deal with his physical health issues and that made a difference to his mental health issues, and he is now back out in the community.

Member of the public: Yes, the majority of the original cuts were in mental health. Do you know the average length of stays out of county compared to the MHRF?
Dr. Henley: A couple of years.

Member of the public: If they switch the MHRF over to a Broderick type facility how will that work? People having been sent back to MHRF from the Broderick facility.

MHRF staff: We transferred 12 people to Broderick, but 5 have been returned.

Member of the public: If we look at the difference been a length of stay at the MHRF of 6-9 months versus two years in out-of-county facilities, it's going to cost the City more money to send people out of county, and that's quite a difference.

Mr. Wise: When MHRF was first built, a lot was riding on getting reimbusrsement that never came. With this conversion, how do we know that the reimbursement will be there this time and that the place won't end up closing completely. From what you've explained it sounds like a lot of what you do is skilled nursing. Has any thought been given to converting it to something like that.

Dr. Henley: We are a skilled nursing facility currently. We are entitled to reimbursement for people under 21 or over 65. That's it. There needs to be advocacy on the state and federal level to change that regulation. If mentally ill people are cared for in a public mental health facility like ours they are not entitled to their SSI benefits and they don't reimburse for services.

MHRF staff person: The morale has been really affected at the MHRF. There is a lot of anxiety right now, not knowing what's going to happen. A client who is 70, was getting better, but now is lethargic. She fears she is going to be left alone.

Mr. Shipley: Have you tracked how much out-of-county beds cost vs. the MHRF? What I've seen is that out-of-county beds cost much more. Some NAPA beds cost $1 million a year. If we are sending people out of county how much money are we really saving by redirecting the MHRF?

3.0 DIRECTOR'S REPORT

3.1 Report from the Director of Community Behavioral Health Services

Ms. Wang distributed the written Director's Report then made the following remarks: The Department has been instructed to prepare contingency cuts, which will be made public on Friday.

In the written report, it is stated that the contingency cut is $27 million for the whole Department of Public Health. These are not definte cuts, but possible cuts. That number has now gone up to $40 million. In addition to the cuts, with mental health services, we'll lose the federal reimbursement funds that the programs produce.

Dr. Del Zotto: What are the root causes of thse tremendous cuts in the City? It didn't happen overnight. Ms. Wang: The dot-com crash is one main problem. The second is that tourism has droppped dramatically since 9-11.

Ms. Brooke: There is a long-term problem in that the City did not buy the buildings it uses for services in the days when property values were much lower. There is a history of not really planning for the long term.

Mr. Luebkeman: On March 19th at the Stonestown YMCA, several of the Democratic clubs on the west side of town will be sponsoring a meeting on the budget with the Mayor's top budget person.

Ms. Wang: The Health Commission is having a budget hearing next Tuesday, March 18, at 3 p.m. at 101 Grove Street.

Dr. Moses: We asked if Dr. Cabaj can come to our Board meeting sometime to talk with us, or could he come to our Executive Committee?

Member of the public: I'm concerned that for the contingecy plan, money for residential services is gone, everything for substance abuse except for methadone will be cut. Forget the safety net, there won't really be a safety net. Westside Lodge will be gone. I'm very concerned about the direction the Department is going in.

Director's written report:

Budget Update. The Mayor's Office is projecting a shortfall of $350 million in FY03-04. To close the budget gap, the Department of Public Health (DPH) submitted a plan to the Health Commission to meet a $17.5 million General Fund target, and $20 million in unavoidable increases. The Health Commission accepted the Department's Plan with minor changes, and the entire plan was submitted to the Mayor's Office on February 21st. The impact to mental health services is a reduction of $2,210,150, which creates General Fund savings of $2,012,345 and a revenue loss of $197,805. The reduced programs include primarily day treatment and outreach programs. The Department is now in the process of preparing a Contingency Plan for submission to the Mayor's Office. The purpose of the Contingency Plan is to outline additional program reductions ($27million) which the Mayor may implement if he is unable to balance the City's budget. The Department's Contingency Plan will be discussed by the Health Commission on March 18.

HIPAA (Health Insurance Portability and Accountability Act). The Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that by April 14, 2003 the privacy provisions in the Act be implemented. The Department of Public Health and contractors are busy preparing for that implementation. The requirements are that every "covered entity" (e.g. the Department of Public Health, contracted health providers) have a privacy policy which meets HIPAA requirements, and that every client receive a notice of privacy practices. In relation to the notice, DPH will be requiring all providers (both contracted and city operated) to use the DPH Summary and Notice of Privacy Practices. The Department has also developed a privacy policy meeting HIPAA requirements, and a privacy policy template based on the Department's privacy policy has been distributed to contract agencies for use should they choose to do so. California's laws/regulations protecting client mental health information is generally more stringent than HIPAA requirements; the intent will be to follow the more stringent requirements and therefore changes in the handling of protected health information are not anticipated to be major.

Request for Qualifications (RFQ). Providers have responded to an RFQ process which was required by the City Administrative Code. Most mental health and substance abuse services were included on a program-by-program, service-by-service basis. Providers were asked to submit a Letter of Intent stating their interest in providing specific services, with basic information on how they meet minimum qualifications. For those services for which more than one provider indicated their interest, all providers who are interested in that service will be asked to submit their full qualifications. Due to the high volume of information to process, the original deadline for submission of these qualifications, which was March 10, 2003, has been extended to March 17, 2003. Technical review panels will be assembled to review the information submitted and to score providers in order to determine which providers should be selected to provide services. Providers who are not selected as the most qualified and responsive may be used as needed in the future. The goal is to develop fiscal year 2003-2004 contracts and present them to the Health Commission from March through June 2003, for a start date of July 1, 2003.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: The next Police Crisis Intervention Training will take place April 21-24.

Mr. Leubkeman: I was appointed to the Public Advisory Committee of Care Not Cash. If anyone has issues they would like me to take to the Committee let me know.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee
Mr. Stinson: Andrea is going to step down as Vice Chair of the Board. The nominating Committee has nominated Augusta Del Zotto as Vice Chair to replace Andrea, and we'll be voting on that position at our April meeting. Ms. Leung: I've started my business as being a private conservator and that is taking a lot of time.

Mr. Stinson: During the past year, one of the reasons for our success was that we had committees working on issues. They helped us come up with resolutions and get into further detail on the issues. I'll be passing around a sign up sheet.

Carol Knight is Chair of Program and Services and Idell Wilson is Co-Chair.
The Public Education Committee is in transition since Andrea is stepping down as Chair of that Committee.

Ms. Knight: The Program and Services Committee is in charge of our MHB program reviews. We also invite guest speakers on issues that we're focusing on.

Ms. Leung: Public Education has focused on increasing Mobile Crisis to 24/7 operation. And we have been studying the Wellness Centers in the high schools.

Dr. Moses: Children's Committee is very important. We should be able to have that committee, too. Mr. Stinson: We'll take that issue back to the Executive Committee.

Board members expressing interest in that committee: Dr. Moses, Dr. Del Zotto, Ms. Shaffer.

RESOLUTION (MHB-2003-06): RESPONDING TO THE BUDGET CRISIS

WHEREAS, the City and County of San Francisco is facing a decline in revenue which in turn is threatening a severe cut in services, and

WHEREAS, these cuts mean a crucial loss of services for individuals in the short-term, and

WHEREAS, these cuts will cause the City to lose highly qualified and very experienced staff during a time when it is already difficult to recruit qualified staff due to the cost of living in our city; and whereas staff who are laid off may be lost to our system permanently, and

WHEREAS, any treatment sites and service facilities which have to be closed down during the current crisis, may be impossible to re-establish in a future year depending on the real estate market, and,

WHEREAS, with regard to mental health services, the Bronzan-McCorquodale Act of 1991 (Section 5600 and following in the State Welfare and Institutions Code) outlines a complete system of care as the most effective and cost-efficient way to provide services and mandates that Counties to the best of their ability provide a comprehensive system of services, and

WHEREAS, in San Francisco, Community Mental Health Services has spent years creating a strategic, cost-effective system of care with a focus on community-based treatment replacing institutional care, which meets the Bronzan-McCorquodale guidelines, and whereas, cuts will fragment that system and damage its cost effectiveness strategies, and

WHEREAS, mental health programs bring in state and federal revenues, and when the reduction of City General Funds cut programs those state and federal revenue will be lost as well, compounding the original General Fund cuts, and

WHEREAS, a severe cut will mean that many clients of the mental health system who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, inpatient units at San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save, and

WHEREAS, the Mental Health Board further believes that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community, and

WHEREAS, the Mental Health Board believes that our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need, now, therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco to respond to this crisis with a comprehensive strategy of revenue enhancement and funding prioritization, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the long-term investment it has made in its services and facilities, including the San Francisco Mental Health Rehabilitation Facility, so permanent damage is not done, and to take all necessary steps to preserve and defend the vital, state-of-the art services the city has developed through years of intensive effort, and

BE IT FURTHER RESOLVED, the Mental Health Board recommends that the City and County of San Francisco do everything in its power to protect the

sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services, and

BE IT FURTHER RESOLVED, that the Mental Health Board recommends that the City and County of San Francisco continue to lobby strongly for parity in mental health care so that the public mental health system is not having to take clients who should rightly be covered by private insurance companies, and continue to lobby for health coverage for all citizens, thereby lessening the burden on municipal public health systems due to the numbers of uninsured or underinsured working citizens, and

BE IT FURTHER RESOLVED, in summary, that San Francisco be a role model and deliver a message to our nation about the importance of protecting our infrastructure and protecting all of our residents, even, or especially, during a time of international crisis and danger, and that we not end up losing the very things we are seeking to defend. (Passed unanimously.)

Mr. Shipley: I have the unfortunate strike against me of being a member of the DPH Strategic Planning Steering Committee that put together the plan on revenue savings for the City in the Deparment of Public Health and suggested several cost cutting measures. It's embarrassing to sit here and know that I was on that committee and the city has developed a strategic plan and what you are seeing now is the result of that. I was the only dissenting voice on that Committee.

Mr. Bevan: I work at the SOMA Clinc. I'd like to thank the Board for your courageousness of taking this on. I've seen other boards in this city so far roll over on this issue. I'm very concerned about the quality of life in this city. Thank you for taking a courageous stand, unlike a lot of other city commissions.

Mr. Warshauer: I'd like to echo that sentiment. I'm very impressed with this Board's activities and this Board's resolution and consider it to be a breath of fresh air. We are by no means considering this budget a done deal. There is a real possiblity of an increase in the Vehicle Licensing Fee, which could dramatically change the state of the budget. And that's just one possibility. Advocacy is very much needed. We will continue and we encourage you to continue. From the point of view of the union, we feel it is our duty to advocate not only for our employees, but for the services.

5.0 NEW BUSINESS

Dr. Moses: Talking about the children's issues, I'd like to invite Sai-Ling to come and brief us about Children's Services. Also can we invite Dr. McConnell to come and update us about quality assurance?

6.0 PUBLIC COMMENT

Mr. Shipley: Spiritmenders is still open. We got a $5,000 grant from the Van Loben Sels Foundation.I am now the consumer liaison in San Francisco to the American Public Health Association which will be having its national conference in San Francisco this year and they would like a large consumer presence.

There being no further business the meeting was adjourned at 8:36 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD
Wednesday, April 9, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA
Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of March 12, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 9, 2003, to the following members: none.

2.0 ELECTION OF VICE CHAIR TO FILL UNEXPIRED TERM (5 minutes)

3.0 PRESENTATION: THE PUBLIC HEALTH BUDGET AND THE INTEGRATION OF COMMUNITY BEHAVIORAL HEALTH SERVICES. (50 minutes)
Barbara Garcia, Deputy Director, Department of Public Health
For discussion.

4.0 DIRECTORS REPORTS (30 minutes)
For discussion.

4.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

4.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

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5.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)
For discussion and proposed action

5.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

5.1.a. PROPOSED ACTION: Be it resolved that the Mental Health Board endorse a joint budget resolution supporting the budget of the entire Department of Public Health. (Attachment B)

5.1.b PROPOSED ACTION: Be it resolved that the Mental Health Board gives the Chair the authority to reconcile final edits of the joint resolution with the representatives of other DPH advisory boards.

6.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

7.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.sfgov.org/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics.

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1380 Howard Street, Suite 510
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MENTAL HEALTH BOARD
ATTACHMENT A
April 9, 2003

CONSENT CALENDAR
All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of March 12, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 9, 2003, to the following members: none.

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MENTAL HEALTH BOARD
ATTACHMENT B
April 9, 2003

A number of DPH advisory bodies are endorsing this statement regarding the budget for the entire Department of Public Health.

A RESPONSE TO THE BUDGET CRISIS FOR THE DEPARTMENT OF PUBLIC HEALTH (MHB-2003-xx)

The Magnitude of the Crisis

Over the past 15 years the Department of Public Health has built a world class system of care. It is far from perfect; there are still many goals the Department is working on. There are parts of the larger vision of public health that the Department is pursuing or would like to pursue, such as the integration of behavioral health services which is now underway.

But there have been remarkable accomplishments. The Department has made very significant progress in moving away from a crisis/institutional strategy to a community-based strategy of care.

This means that we are meeting the needs of our public health clients in a more effective and humane way, and it means we also maximize the use of each dollar spent on healthcare. We are focusing on prevention and early intervention strategies. A crisis-based strategy seems expedient but it is financially wasteful and counterproductive.

The most important feature of our system of care is that it is a system. All the parts work in harmony to produce cost savings while enhancing the effectiveness of treatment.

San Francisco has every reason to be proud of the public health infrastructure it has built. It's required a significant transformation of the way health programs worked in past years. It's been a labor of love, in that many of our veteran staff have invested a significant portion of their careers in creating this system of care.

Now this system, one of the treasures of San Francisco, is threatened by proposed and budget cuts.

We are not talking about a small dip in funding this year, which can easily be corrected in a future year. We are looking at the most severe cuts in years. We are looking at compounded cuts. When a program is shut down, there is a loss of the federal and state revenues that program was bringing in. So a cut of $2 million of General Fund moneys may well mean a loss of $3 million of services.

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A severe cut will mean that many clients who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, San Francisco General Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save.

An additional irony is that at a time when more people are in need, we will have fewer services. That's bad enough, but even worse is the fact that the severity of the cuts may mean that we will be doing irreparable damage to our system of services.

The Danger of Doing Permanent Damage to our Healthcare Infrastructure
The losses we suffer through the cuts in 2003/04, are losses San Francisco may not recover from for a decade or more.

> It's already a challenge to recruit qualified staff due to the high cost of living in San Francisco. Staff we lay off during this crisis, may well be lost to our system permanently. They will move away or take other jobs.
>
> When we lose experienced staff, we lose much more than individual staff. We lose a network of working relationships which is key to making our system of care successful.
>
> Program and residential facilities which are lost to our system are likely to be permanently lost, because of the high-priced real estate market. It's also very challenging to open or re-open a program in San Francisco.

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We urge the leadership of the City and County of San Francisco to respond to this crisis with a comprehensive strategy of revenue enhancement and funding prioritization, not just a cutting strategy, and to do a thorough and comprehensive review of all the City's revenue sources.

We urge the City and County of San Francisco do everything in its power to protect the sustainability of the community-based nonprofit organizations which deliver such a large percentage of its public health services.

We urge the City and County of San Francisco to use the full force of its political power to help shape state and national policies so that the priority will be placed on taking care of all the people of our nation, given that our people are the key to our strength.

In Summary

We believe that a strong and effective public health system directly benefits all neighborhoods and economic sectors of the community.

We believe our community has a moral and ethical duty to care for those people who are ill, suffering, in trouble, and in need.

We believe that San Francisco should be a role model and deliver a message to our nation about the importance of protecting our infrastructure and protecting all of our residents, even, or especially, during a time of international crisis and danger, and that we not end up losing the very things we are seeking to defend.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
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UNADOPTED MINUTES
Mental Health Board
Wednesday, April 9, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Augusta Del Zotto, Ph.D. (Acting Chair); Bridgett Brown; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Rose Chung for Supervisor Aaron Peskin; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Bob Douglas; Ted Stinson (Chair), Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: none.

PRESENTERS:
Barbara Garcia, Director of Community Programs, and Deputy Director, Department of Public Health

OTHERS PRESENT: Bill McConnell, Ph.D. (Associate Director, Quality Management, Community Mental Health Services); Mike Wise (Voices at Bay, San Francisco Network of Mental Health Clients); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was called to order at 6:45 p.m. by Toye Moses, Secretary of the Board.

1.2.a RESOLUTION (MHB-2003-07): Be it resolved that the minutes of the Mental Health Board meeting of March 12, 2003, be approved as submitted. (Passed unanimously.)

1.2.b RESOLUTION (MHB-2003-08): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of April 9, 2003, to the following members: Ted Stinson, Bob Douglas, Dennis Yun. (Passed unanimously.)

2.0 ELECTION OF VICE CHAIR TO FILL UNEXPIRED TERM
Augusta Del Zotto was unanimously elected to fill the position of Vice Chair of the Mental Health Board. Dr. Del Zotto then became the Acting Chair and chaired the remainder of the meeting.

3.0 PRESENTATION: THE PUBLIC HEALTH BUDGET AND THE INTEGRATION OF COMMUNITY BEHAVIORAL HEALTH SERVICES

Ms. Garcia: I'd like to start with the big picture of what's happened, then get to the specifics. Our theme this year is: Hoping for the best, but preparing for the worst.

The situation is very fluid. Every day is different. We've been planning this budget since December. There is a $347 million deficit for the next fiscal year. We were asked for another $40 million in contingency cuts for next year. The Health Commission approved some contingency cuts, then sent the Mayor a resolution saying: No more cuts; we're not going to support any more cuts.

The General Fund provides 25% of our DPH budget. In the City budget, there is only about $1 billion of discretionary money. The rest of it comes from revenues dedicated to certain programs or mandates.

We have about a $20 million cost increase just to stay even. We have MOU's with the unions and increased pharmacy costs.

In the Department of Public Health there are two major hospitals, Laguna Honda and San Francisco General Hospital. Both of these are very importants part of our system of care. We're probably the only Health Department in the world that has a housing component. We see the link between housing and health care, and how important housing is in stabilizing people.

The hospitals are not a big focus of the cuts. For every dollar we spend in the hospitals, we receive $3. We also need to serve the poor and provide the safety net. So then we had to look at the community-based programs for the cuts. We have re-programmed the MHRF. We have eliminated vital outreach services. We've cut substance abuse programs. We've cut day treatment programs.

The budget has gone to the Mayor now. We still may be asked for $27 million more in contingency cuts. Now there will be a competition between the Health, Fire, and Police departments.

We're doing an analysis to deal with the ramifications of cuts. With each community based organization (CBO) that you cut, you also have to give them mindful attention. We're working with those organizations and the union. We're working on how they can restructure themselves. If they are getting a $1 million cut, what can they do? We want to help them survive. One of the things we've done is to work on reducing acute care, moving people to community-based services.

We will continue to work on that. For the future, we are also reorganizing ourselves as Community Behavioral Health Services, integrating CMHS and CSAS. It's even more important to do that now, because we will have fewer resources. We're thinking about bringing CSAS and CMHS closer together more quickly, to be able to treat people in a holistic way.

It's a terrible cut that we are facing, but we still have a lot of programs out there. We did not cut youth programs, and tried to stay away from cutting women's and children's programs.

We tried to use the Strategic Plan as much as possible, but the cuts are so deep, we couldn't follow it all the way.

Dr. Moses: I know that many years ago we fought so hard to have the Mental Health Rehabilitation Facility so we could bring our consumers back into San Francisco from Napa State Hospital. Now that's turned around again and we'll be sending clients out of county again.

I know the CBOs are doing such a great job and now some of them are getting such deep cuts that they might have to close down. What will happen to the clients? In Bayview, especially, we are losing a lot of programs.

Ms. Garcia: On the MHRF question, the obligation we have is to make sure individuals are at the level of care they need to be at. Not all of the people at the MHRF need to be there. There are about 50 people we'll be moving to other locked facilities, such as Crestwood and Napa.

The licensing for a skilled nursing facility (SNF) is stricter than residential care. The MHRF was a $15 million General Fund program with under $1 million in revenue. That's because of the federal regulations. The idea was to try to create a model that would generate more revenue while providing a service that is needed by our clients.

We believe this is an equitable cut, because so few cuts came out of other parts of SFGH. We're not closing the MHRF. It will still be providing services. The larger institutions are structured so that you can't cost effectively pull funds out of them. We felt it was more equitable to have a cut come from the hospital and be able to save so many community-based programs.

The change in the MHRF will mean that we will move individuals who need a high level of care. The MHRF will be a residential facility.

Dr. Moses: Will it be a CBO that runs it? Ms. Garcia: It could be.

Dr. Del Zotto: I want to commend you for preserving a lot of the women's and children's services. How did you pull it off? How much was in mental health?

Ms. Garcia: We couldn't pull it off entirely, but Mitch Katz was very supportive of this. We looked at programs that were not performing well and they were cut first. But then we had so many more cuts we needed to make.

Individuals with addictions are not allowed to have SSI, so it is totally the responsibility of the local jurisdictions to provide treatment for them. CSAS is 100% dependent on the General Fund, and it was impossible not to cut them.

We tried to make necessary cuts while doing the least harm. But there was no way not to have harm as a consequence.

With regard to the Bayview Hunters Point Foundation, I met with them today. In these times, it's more important than ever to work together. The management and union are talking about working together and that had historically been a division. I worked on that for the last 2-3 years.

When we were going to cut the health centers; it was a real struggle. How do you do that? Finally, we said we would keep all the health centers open with a small staff, so the centers will be there when the budget goes back up.

We also did not want to cut a center and sell property. We did not want to cut a center in one neighborhood and pit that neighborhood against other neighborhoods.

Mr. Luebkeman: Everyone knows we are in dire financial times. We can see that with United Airlines. They are going to unions to ask for help. How much is that part of the process here?

Ms. Garcia: That is a big part of the picture for us. We are working with unions on give backs. We're hoping for $75-80 million savings citywide. We'd like to have people pay for their own retirement savings. We're really counting on that.

Let me walk you through the budget process. The Department staff completes the budget, which we finished yesterday. The Health Commission approved it and sent it to the Mayor's Office. We can just sit here and watch the cuts happen or we can be proactive. I saw in your MHB resolution that you are talking about being proactive.

Mr. Luebkeman: How are these cuts identified? What is the process?

Ms. Garcia: We were given a target for the whole Department. Then each area gets a target goal. It's difficult to do a budget process like this with a big group of people. I start by talking with my executive team. Each area goes into their own process to try to meet the target they are given.

I make sure each section has an equitable pro-rated cut. Mitch Katz sets some major direction. Then I manage my areas, and work closely with the people in each area and they each have a target. And the team works pretty well together. Then I work with my budget people to work out the mechanics.

Dr. Moses: The MHRF will not be terminated, is that right?

Ms. Garcia: The MHRF will be terminated as a skilled nursing facility. But it will be operated as a residential facility. The big problem is not politics, but finance. It's the financial reality. So in terms of your advocacy strategy, we encourage people to come to hearings. It's made a great impact for people to come to the Health Commission meetings. There are other strategic decisions coming up for the City as a whole.

Mr. Martin: The Substance Abuse Mental Health Work Group of the Coalition on Homelessness met with the Mayor's budget director yesterday, and suggested the closing CJ7 (criminal justice facility) instead of the MHRF because that's where the people from the MHRF will go if the MHRF is changed.

Ms. Garcia: The problem is that we still need to handle that $8 million gap in the budget. There is no way we will get $8 million out of SFGH. It's a $15 million program. MHRF. We need to fill that $8 million hole.

I'm directed to implement and I'm going to do the best job I can do. I'm asked to cut and I'm going to do the best job I can do.

Ms. Shaffer: We're going to have so many more people needing the resources because of the downturn of the economy. There will be a greater demand on the system of care. And then we'll have to use costlier services.

I'm dealing with this in the schools where I work. It's getting to the point where every day is a crisis. Today was terrible. And we're not even to July yet.

Ms. Garcia: There is no way we are going to serve more people. We are going to serve fewer people. And more of them will be at the higher end. There is going to be harm. We know that $1 saves $7 in substance abuse programs, so that means we just lost $49 million.

I'm working on capturing new revenue and old revenue. In a civil service department we can do a lot better at capturing revenue. Maybe it took the pressure of cuts. Providers do the best job they can for the clients and at the end of the day the paper work may not get taken care of. But people are now more aware of the importance of revenue capture.

We're also looking at overlap between departments. There are 800 clients in Human Services who are also in CMHS. They don't have advocacy to get on SSI.

Member of the public: The 50 people who won't be able to be in the MHRF, where will they go? Ms. Garcia: We have a variety of programs we contract with in the area and outside the area.

Member of the public: Will MHRF still be a locked ward? Ms. Garcia: No. It will be a residential facility.

Mr. Wise: I was at a retreat today. I wanted to focus a couple questions on the re-licensing of the MHRF. I've heard that to re-license the MHRF, it has to be emptied totally. Is that so? Ms. Garcia: We are still negotiating that with state licensing.

Mr. Wise: Gene McConnell, Director of SFGH, two weeks ago said: We have to notify state licensing right away about this. And actualizing the design of the MHRF may take longer than July 1st. We'd have to find out what community based organizations would be interested in running the facility.

Is there any news about these items?

Ms. Garcia: About the first issue, there is still a debate on whether we have to close the MHRF then re-open it. There are two different opinions on this. I believe we sent the letter out on notification. About the RFP process, we had to decide, should the City hold the license? DPH will hold the license. We will RFP out some of the services, such as money management services, support services, etc. We expect we will save $8 million from the redesign. There are lots of debates going on, plus union concerns, and potential lawsuits.

Ms. Brooke: Is there any wild chance of getting a 24-hour Mobile Crisis program?
Ms. Garcia: I've tried doing that twice in every budget year. The problem right now is I would have to cut from somewhere else to do it. But it is definitely needed. But if any new money comes down the line, then it would be a focus.

I have to support the MHRF redesign, because it saves $8 million of community programs.

Mr. Martin: The sell on the 24-hour Mobile Crisis is that it is the nexus where criminal justice and jails intersect with mental health. Also The People's Budget identified $1.6 million in performance bonuses.

Ms. Garcia: We're paid pretty well as City administrators. My value system has always been that when you make more money, you work harder. I think there are many of us who would be willing to take pay cuts. I think all of us have to do our fair share.

The Mental Health Board is a very powerful group. Where you do your advocacy is important. There are lots of people who will not be served next year. So we have to think smarter about how we do our work. I'd welcome any ideas you have about how to do that.

4.0 DIRECTOR'S REPORT

4.1 Report from the Director of Community Behavioral Health Services

Dr. McConnell presented the Director's report on behalf of Dr. Cabaj:

Budget Update. The Department has submitted a FY03-04 budget, which has been approved by the Health Commission, and submitted to the Mayor's Office in February. The second step is to prepare a Contingency Plan of additional reductions for submission to the Mayor's Office to be used in the event that the Mayor is unable to balance the City's budget. The Health Commission has reviewed the initial Contingency Plan, and will review the final plan on April 8th at their regular meeting. Due to the budget shortfall projections issued by the Mayor's Office on March 17th, which indicate the City's budget shortfall is even larger than originally expected ($347 million projected in FY03-04), it is certain that some portion of the Contingency budget will be moved from the Contingency Plan to the baseline budget. In other words, there will be additional program reductions to CMHS unless the Mayor or the Board are able to find alternatives to balance the budget. The impact to CMHS has not yet been determined,

and will be reported in the next update. Alternatively, this information will be available on the DPH website as of April 4, 2003, or at the April 8 Health Commission meeting.

Dr. Evelyn Lee, Ed.D. Dr. Evelyn Lee passed away on March 26, 2003. Dr. Lee was Executive Director of RAMS for over a decade, and before that, she was Chief Program Director of the Department of Psychiatry at San Francisco General Hospital. She contributed greatly in her teaching, program development and community activities, particularly in the areas of cultural competence and working with immigrant and refugee trauma. The RAMS Board has appointed the RAMS Clinical Director Philip Tsui, LCSW, as Interim Director.

Critical Incident Response Team. The two-person CIRT is now operational. This service is now city operated, providing outreach, crisis counseling, debriefing services and support to victims of violence, focused on the Bayview/Hunter's Point, Visitation Valley and Potrero Hill areas of the City. In its first few months, it has provided assessments, case management including assistance with relocation, assistance with funeral services, crisis counseling, and referrals. The CIRT is also participating in training of community groups on such topics as mental health and spirituality.

HIV Mental Health Case Management at Center for Special Problems. The Title IV funding that Center for Special Problems has received through the sub-contract with UCSF through July 31, 2003 has enabled our HIV Mental Health Case Management team at CSP to provide mental health services to thirty four women living with HIV in the first seven months of the contract year and has also been able to provide services to eight of these women's affected family members. The program will also be providing both couples and family therapy to additional persons living with HIV.

The increased funding has provided for the placement of a social worker one morning a week at the UCSF Women's Specialty Clinic located at 400 Parnassus. This has dramatically enhanced women's access to mental health service as the social worker provides brief counseling and assessments on-site and then links those in need to longer term mental health care at Center for Special Problems. Also, as a direct result of the collaboration with the Women's Clinic at Positive Health Practice located at San Francisco General Hospital's Ward 86, positive women are accessing mental health care in a far more timely and seamless way.

The HIV Mental Health Case Management Team at CSP also provides mental health services to men living with HIV.

Transgender Life Care Project. The Transgender Life Care project is now fully staffed and operating at capacity at Castro-Mission Health Center and providing support group and outreach through the UCSF Center for AIDS Prevention Studies. This project was originally funded for three years. However, the president's budget for 2004 has eliminated the third year of funding for this project. We have received a number of letters from the community expressing concerns. While we continue to look for alternative funding sources for this project, there is no guarantee that this program will continue in its present form next year.

AB 2034 Homeless Outreach Program Update. The AB2034/MOST Program at the South of Market Mental Health Clinic was funded by the State in late 2000 to serve 120 homeless individuals who are severely mentally disabled and who have not successfully linked in the past to community-based mental health services. Many of the enrolled clients have histories of frequent hospitalizations and/or incarcerations. The program provides intensive clinical and wrap around services and is based on the recovery philosophy. Consumer participation is encouraged at all levels of programming including representation on the Consumer Advisory Board.

Profile:
- 121 Clients Currently Enrolled
- Primary Diagnoses: 75% Psychotic Disorder, 24% Mood Disorder, 1% Anxiety Disorder
- Substance Abuse: 69% of Clients have co-occurring alcohol or substance abuse
- Special Populations: 20 or (16%) of clients are transitional aged youth (18-24)

Outcomes:
- Data from 1/31/03: Reduction Rates are annualized and based on activity for 12 months prior to enrollment compared to all post enrollment activity.
- 46% Reduction Rate for Hospitalization Days
- 72% Reduction Rate for Incarceration Days
- 79% Reduction Rate for Homeless Days

Housing
- As of 3/31/03, 51 clients are placed in the new DAH units at the Star and Camelot Hotels--55 units at these buildings are designated for AB2034 clients
- A total of 91 (75%) of 121 enrolled consumers are living independently

Employment Update:
- Nine (9) AB2034 Consumers began a new stipend workers program in March. Participants of the stipend workers program work 5 hours each month at $8.00 per hour. The stipend work positions include janitors, gardeners/grounds keepers, and activity assistants for such things as the MOST Team coffee club, movie night, and bowling outings.
- As of February 28, 2003, 8 of the 121 enrolled AB2034 consumers remained homeless.

Mr. Martin: I have a couple good friends who have been working on the MOST Team and it has probably been the most effective program for homeless people I have seen in the 13 years I have been working on that issue in San Francisco. If you have the resources you can engage people and get the kind of great results they're getting.

Dr. McConnell: The value of good data collection to prove the effectiveness of the programs to Governor and legislature.

4.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: I heard today that Spiritmenders got a $4,500 donation. The Police Crisis Intervention Training will take place April 21-24.

5.0 MENTAL HEALTH BOARD COMMITTEES

5.1 Report of the Chair of the Board and Executive Committee
Ms. Brooke: Ted has been instrumental in producing this resolution. He presented it to the Treatment on Demand Council. It has now been endorsed by the Treatment on Demand Council, the Citywide Alcohol Advisory Board, and the Drug Abuse Advisory Board. The idea is that all the advisory boards will be stronger if we are advocating together instead of separately.

A RESPONSE TO THE BUDGET CRISIS FOR THE DEPARTMENT OF PUBLIC HEALTH (MHB-2003-09)

The Magnitude of the Crisis
Over the past 15 years the Department of Public Health has built a world class system of care. It is far from perfect; there are still many goals the Department is working on. There are parts of the larger vision of public health that the Department is pursuing or would like to pursue, such as the integration of behavioral health services which is now underway.

But there have been remarkable accomplishments. The Department has made very significant progress in moving away from a crisis/institutional strategy to a community-based strategy of care.

This means that we are meeting the needs of our public health clients in a more effective and humane way, and it means we also maximize the use of each dollar spent on healthcare. We are focusing on prevention and early intervention strategies. A crisis-based strategy seems expedient but it is financially wasteful and counterproductive.

The most important feature of our system of care is that it is a system. All the parts work in harmony to produce cost savings while enhancing the effectiveness of treatment.

San Francisco has every reason to be proud of the public health infrastructure it has built. It's required a significant transformation of the way health programs worked in past years. It's been a labor of love, in that many of our veteran staff have invested a significant portion of their careers in creating this system of care.

Now this system, one of the treasures of San Francisco, is threatened by proposed and budget cuts.

We are not talking about a small dip in funding this year, which can easily be corrected in a future year. We are looking at the most severe cuts in years. We are looking at compounded cuts. When a program is shut down, there is a loss of the federal and state revenues that program was bringing in. So a cut of $2 million of General Fund moneys may well mean a loss of $3 million of services.

A severe cut will mean that many clients who go unserved will end up in very expensive institutional care—Psychiatric Emergency Services, San Francisco General

Hospital, the county jail—or will end up homeless and out on the streets, with the possible ironic outcome that the cuts may cost the City more than they save.

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We believe that San Francisco should be a role model and deliver a message to our nation about the importance of protecting our infrastructure and protecting all of our residents, even, or especially, during a time of international crisis and danger,

and that we not end up losing the very things we are seeking to defend. (Passed unanimously.)

RESOLUTION (MHB-2003-10)
Be it resolved that the Mental Health Board authorizes its Chair, Ted Stinson, to do any final editing that's necessary to reconcile the joint resolution (MHB-2003-09) with the other DPH advisory boards. (Passed unanimously.)

6.0 NEW BUSINESS
Dr. Moses: I'm still concerned about the Board or the Executive Committee being able to meet with Dr. Cabaj.

Mr. Martin: There is a problem of the age-old stigma question. At the recent Prop N Implementation meeting, Lindsay Coleman, Director of Next Door, said there was an increase in violence, and the reason she gave was increase in the number of mentally-ill shelter residents.

Statistically, mentally-ill people are far more likely to be victims of violence rather than perpetrators. Jenny Friedenbach of the Coalition on Homelessness challenged her on that remark, but several people chimed in to agree with Ms. Coleman, including the Director of Catholic Charities, Brian Cahill.

Then I picked up the paper Monday and in the column by Matier and Ross, the Mayor was saying that we have 20,000 psychiatrists coming to San Francisco for the APA convention. He said, I told them I have 748,000 patients here. Do you think we can do a deal?

I don't know who the Mayor is dissing worst with this remark, the people with mental illness or the other citizens of San Francisco.

I would like us to draft a letter to those key players. Even the National Alliance for the Mentally Ill spends millions each year to counter stigma, and it's our civic leaders who are perpetuating it.

Dr. Del Zotto: The derogatory things you can say against mentally ill people are incredible. Mr. Luebkeman: This statement is in incredibly poor taste.

Shaffer: I suggest we write a generalized statement. This was one of the things I dealt with today at work. People think it's okay to call kids crazy, and their parents crazy, and to call kids with mental illness deficient. We need a statement to help people understand.

Mr. Luebkeman: I have an item for future discussion. Everyone knows we are in a conflict in Iraq and a lot of young men and women will come back home having experienced some really terrible things. Maybe it would be appropriate to draft something to send to the Board of Supervisors, that it would be important for the Veterans Administration not to turn their backs on veterans who have mental illness problems due to what they saw while serving the US Government in Iraq.

7.0 PUBLIC COMMENT

Mr. Kalman: This is not the first time the Mayor has made these kind of remarks. I don't think he really means it, because he's very supportive of the Mayor's Disability Council.

Dr. Moses: The APHA Conference will be held in San Francisco in November. I'd like to see us be active in that.

There being no further business the meeting was adjourned at 8:26 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, May 14, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar (Attachment A)

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of April 9, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 14, 2003, to the following members: Bridgett Brown

2.0 PRESENTATION: FAMILY MOSAIC PROJECT (50 minutes)
Roban San Miguel, Executive Director, will provide an overview.

30 DIRECTORS REPORTS (30 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

4.1.a. PROPOSED ACTION: Be it resolved that the Mental Health Board proposes ensuring quality physical and mental health services for our returning service people. (Attachment B)

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

DISABILITY ACCESS

1. American Sign Language interpreters and/or a sound enhancement system will be available on request. Please contact Ladonnis Elston at (415) 255-3444 (voice) or (415) 255-3449 (TTD) 5 days before the meeting. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at 1380 Howard Street (corner of 10th Street), in Room 537. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and the 72 Haight/Noriega. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The main entrance to 1380 Howard is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on Grace Alley which runs on the opposite side of the building from 10th Street.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

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Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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To view Mental Health Board agendas and minutes, you may visit the MHB web page at: **www.sfgov.org/mental_health**. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

MENTAL HEALTH BOARD
ATTACHMENT A
May 14, 2003

CONSENT CALENDAR
All items on the Consent Calendar are handled through a single vote. There will be no discussion unless a member requests it, in which case the item will be removed from Consent Calendar and discussed. Additional names may be added to the leave of absence resolution during the meeting.

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of April 9, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 14, 2003, to the following members: Bridgett Brown.

SAN FRANCISCO MENTAL HEALTH BOARD

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MENTAL HEALTH BOARD
ATTACHMENT B
May 14, 2003

PROPOSED RESOLUTION (MHB-2003-xx): ENSURING QUALITY PHYSICAL AND MENTAL HEALTH SERVICES FOR OUR RETURNING SERVICE PEOPLE.

WHEREAS, tens of thousands of young people from the United States, both citizens and non-citizens, along with veteran officers, are now engaged in military action in Iraq, and will continue to be engaged in Iraq following the end of armed conflict, and

WHEREAS, many of our service people have partaken in fire fights and have had to kill people for the first time in their lives, and whereas they have been witnessing death and destruction on a scale they have never before experienced, and whereas they have been and will continue to be subjected to extraordinary stress and danger, and

WHEREAS, in past wars and incursions, the U.S. military and Veterans Administration have not always responded adequately to the physical and mental health issues of service people, now therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco and San Francisco's Congressional delegation to take what steps they can to make sure the Veteran's Administration and the Department of Defense meet the physical and mental health needs of our returning service people immediately with comprehensive, quality services, which are also culturally competent.

Watch for Family Mosaic Project on Channel 7 ABC KGO San Francisco

(Check local listings for times)

During the Month of May 2003

The Family Mosaic Project appears in a three-part series:

The Mental Health of America's Kids

Part 1: Crossing the Line: When has a child crossed the line of "normal behavior"?

Part 2: Misdiagnosis: ADHD and Bipolar: Are children being diagnosed as ADHD without ever looking into bipolar as a possibility?

Part 3: Helping Children Help Themselves: A family and staff from Family Mosaic Project were interviewed for this segment, along with families and staff of the Preventive Intervention Nurse Home-Visitation Model in Denver, Colorado.

This three-part series was produced by Ivanhoe Broadcast News
Head quartered in Orlando, Florida.
It is the country's largest television news-gather organization covering medical breakthroughs, family health, and issues of importance to women.

The video series may be viewed during the month of May 2003 on Ivanhoe Broadcast News website: http://www.ivanhoe.com

(See the reverse for more details on the series)

MAY 2003

THE MENTAL HEALTH OF AMERICA'S KIDS

PART 1: CROSSING THE LINE

When has a child crossed the line of "normal behavior"? When does it become "abnormal" for a child to suffer separation anxiety attacks? When is a child too "old" for acting aggressively toward others? In this report, we'll cover the signs and symptoms to watch for to determine if your child could have a mental health disorder. We'll also explore the triggers for episodes of disorders such as mania, depression, withdrawal, anxiety and panic attacks in high-risk kids and in those who have already received a diagnosis.

PART 2: MISDIAGNOSIS: ADHD and BIPOLAR

Nearly 1 out of 100 children and teens worldwide have bipolar disorder. Bipolar disorder is commonly misdiagnosed as ADHD—in fact, up to 15 percent of children thought to have ADHD may actually be bipolar. Many doctors readily diagnose a child with ADHD, without ever looking into bipolar as a possibility. The danger here lies in the fact that the standard treatment for ADHD, a stimulant, can be deadly if given to a child who really has bipolar. It can trigger mania or depression and may lead to suicidal tendencies. Here, we'll tell stories of children, diagnosed with ADHD, who really have bipolar disorder. We'll explore what they and their parents had to go through to get the correct diagnosis. An additional element to this story is that the FDA just approved the first drug for ADHD that is not a stimulant, called atomoxetine.

PART 3: HELPING CHILDREN HELP THEMSELVES

In a world where the quickest way to fix a problem is with a pill, we've found some alternative treatment programs that work to spare young children a lifetime of medicine, while keeping their mental health in check. One program is the Preventive Intervention Nurse Home-Visitation Model. The idea is simple: Intervene with high-risk families to prevent negative consequences to their kids. Met with phenomenal success, the program has expanded its reach to two more study sites, in hopes of creating a nationwide model. Another program is the Family Mosaic Project in San Francisco. Kids who have already been diagnosed with a mental illness are guided through a treatment program that offers a wrap-around approach involving mentors, care workers, family and medical professionals. We'll introduce you to a child with bipolar disorder who has gone through the program and now needs no medication to keep his illness under control.

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UNADOPTED MINUTES
Mental Health Board
Wednesday, May 14, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Augusta Del Zotto, Ph.D.; Jay Golub; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; chance martin; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Dennis Yun, M.S.W

BOARD MEMBERS ON LEAVE: Bridgett Brown; Bob Douglas; Rose Chung for Supervisor Aaron Peskin; Idell Wilson; Sandy Yuen.

BOARD MEMBERS ABSENT: None.

PRESENTERS:
Roban San Miguel, Director, Family Mosaic Project
Consuela Bradford, parent of two children in the Family Mosaic Project
Esperanza Echavarri, Program Director, Children's System of Care
Cynthia Billups, Coordinator, Family Involvement Team
Victor Damon, Youth Task Force Coordinator, Children's System of Care.

OTHERS PRESENT: Bob Cabaj, M.D. (Director, Community Behavioral Health Services); Tom Purvis (National Alliance for the Mentally Ill—San Francisco); Charles Anderson (Walden House); Mike Wise (Voices at Bay, San Francisco Network of Mental Health Clients); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was called to order at 6:43 p.m. by Ted Stinson, Chair.

Mr. Stinson: I'd like to introduce our new Board member, Jay Golub, who was appointed to a Family Member Seat by Supervisor Gavin Newsom. Jay is a lawyer, and graduated from Columbia University with a BA in Political Science.

Mr. Golub: I was a lawyer in New York City for a while. I'm now the head of Summerbridge, a nonprofit school for 5th and 6th graders. I'm happy to be here. It seems like a warm place. I hope to add to what everyone's working on, and bring in my new ideas where appropriate.

1.2.a RESOLUTION (MHB-2003-11): Be it resolved that the minutes of the Mental Health Board meeting of April 9, 2003, be approved as submitted. (Passed unanimously.)

1.2.b RESOLUTION (MHB-2003-12): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of May 14, 2003, to the following members: Bridgett Brown, Bob Douglas, Rose Chung for Supervisor Aaron Peskin; Idell Wilson; Sandy Yuen. (Passed unanimously.)

3.0 PRESENTATION: FAMILY MOSAIC PROJECT

Ms. San Miguel: I worked at the Real Alternatives Program (RAP) for 13 years, and at the Women's Clinic and Teen Clinic at San Francisco General Hospital. I've been the Director of the Family Mosaic Project (FMP) for 5 months.

Tonight I've brought with me my partners in the work the Family Mosaic Project is doing. FMP came out of an initiative from the Robert Wood Johnson Foundation. From San Francisco's perspective this was really important. We had about 1,000 youths involved in multiple programs and agencies, such as the Youth Guidance Center and our mental health system.

When I was at RAP, I was one of the community members who attended forums to get the Robert Wood Johnson grant off the ground.

FMP was the beginning of the wrap-around concept in San Francisco. Later it was important to look at alternative funding streams in order to continue the program. We looked at capitated programs through the state. They were great for Medi-Cal eligible people, but not great for children without Medi-Cal. The Children's System of Care took on the task of expanding intensive case management to those children and families. (Ms. San Miguel then distributed a handout about the FMP.)

We are at the table with our families, and we make joint decisions about what the family or child needs. Our wrap-around services are in addition to therapy, and include such things as mentoring, tutoring, and dance classes. For one of our clients taking a dance class made such a difference. It allowed her to develop a sense of self-esteem and begin making progress. We look at all kinds of resources.

Ms. Bradford: I'm a single parent of two minors and an adult daughter who is 30 years old. I got involved in FMP after my son became labeled 5150. I had seen the changes in his behavior, and was referred to FMP, but I was not eligible then. My son was hospitalized in Concord because there was no inpatient program for children in San Francisco. I was crying out for help.

For parents who are in denial, or for those without coverage, we need to look at some type of early intervention before the labeling happens. I feel deep down in my heart that these young people committing crimes are undiagnosed mentally ill. My son wrapped his arm around my neck, and began lifting me off the ground. In Burlingame, he went ballistic in a restaurant. The police said they had to take him in. I want to commend the Burlingame police, because they were trained to help.

The San Francisco Police told me to go home and beat his butt. But I said, "If I did that, you'd take him away form me." I've been collecting newspaper articles about bi-polar people being hurt by police.

I thank God for FMP, with their wrap-around services. I was told that my son would be on meds for the rest of his life, but he's now been off meds for two years.

My daughter and I were his victims. I could not sleep at night for fear of what he might do. One night I awoke to him being very upset and standing over my bed, and I had to calm him down. Now he's in a special education classroom with eight other boys. I go to his school. I let them know that they are special. The teacher called me today and told me how when I come into the classroom how good the spirit is in the classroom, how well my son responds.

My focus now is early intervention, when a child is 4, 5, or 6. But if there is no label on the child, there is nothing for them. Governor Davis wants streets to be safe, but he wants to do it with prisons. I want the streets to be safe, too. But the streets are filled with people with mental illness, with nowhere to go. The Governor is taking money away from the schools, and away from these programs.

My son is taking a music class and he has a mentor, because his father is not with us and it's all women around him.

Ms. Echavarri: We want to be able to get the word out to the public and let people know what we are doing in the Children's System of Care. (Ms. Echavarri then handed out a newsletter with the principles of the CSOC.)

There was an initiative from the State called AB 377 which started in the 1980's when San Francisco was organizing the FMP. The State had an initiative for a coordinated wrap-around intensive case management program in Ventura County. A lot of the kids were being being taken out of their homes and put in residential care. In San Francisco, the rate of out-of-home placement was sky high, higher than elsewhere in the state.

The CSOC is providing services to maintain children in the home and in the community. And for that we needed coordinated care. There was some State funding that came through for counties who adopted the Ventura County model. The program had to be child-centered and family-focused. You have to have families and parents involved in the process.

We saw that we needed to engage our partners in a more proactive and strategic way to close the gaps in the system. We organized a CSOC Planning and Policy Council of over 60 organizations to develop the work plan. We created a Steering Committee with representatives of all child-serving City Departments. We are focusing on how we can do alternatives instead of sending so many children to out-of-home placements.

In 1996/97, we got a grant for that work plan. We needed to build another intensive case management team to compliment the FMP program. We also recruited and hired peer parents who had navigated the system on behalf of their own children. We were

able to hire 5 peer parents. They really have been the catalyst for change in children's mental health.

CSOC was designed to be flexible. We developed liaison positions and coordination efforts for each of the City Departments. We had the key directors, including Sai-ling Chan-Sew from CMHS, Jesse Williams, Chief of Juvenile Probation, Bill Betancourt from the Department of Human Services. There was an agreement on core principles. We decided to look at the youth involvement piece since family involvement was so successful.

To have people agree to plan together and see how to leverage dollars. Dollars are very specific in children's services. We need to be flexible to meet children's needs. We have worked hard to leverage dollars and bring flexibility to funding streams. We've received a cut from the State which cut our funding in half, and put our program at risk. But then we applied for and received a significant SAMHSA grant to implement the things we've learned over the last 5 years.

Ms. Billups: I'm the Coordinator of the Family Involvement Team. We're the parent group in the CSOC. We work very intensively with the Family Mosaic Project.

What we do is to give direct parent-to-parent service, while everyone else is focused on the child. We try to give the parents a sense of hope and a sense of direction as they negotiate the mental health system and other systems. We help them when their child is threatened with out-of-home placement.

We want to let them know that there is hope. We've been there ourselves. We all have kids who have special needs and we have been challenged in many different ways.

Parents and families have a right to be engaged in their child's treatment, and the better they feel about the plan and the more active they are with it, the better the results. It feels like less of a punishment then, because you are involved and making a difference.

We are formulating a Youth and Parent Council that will allow parents to give us oversight. We are very good at checking in with people and asking if what we are doing is helpful. We want to make sure as we roll out the continuum of services that we are doing the job that people need.

It's our intent to engage with the other clinics. We have the option of connecting with parents wherever they are. They don't have to be linked to treatment. We help people with what their most immediate need is. It might be that they need food. When you have helped them with other things, then they are more open to receive services.

We try to hang in there with folks; I think that's key. You just keep hanging, and keep on keeping on. We have seen many successes.

Mr. Damon: I'm the Youth Coordinator for CSOC and run a program called the Youth Task Force. The program consists of 14 to 18 year olds who are consumers in multiple systems, such as mental health, special education, juvenile justice, group homes, etc.

Dr. Moses: I'm happy to see that Family Mosaic is still alive. I remember years ago FMP was dying and as a result of that Supervisor Kennedy made it possible to have a Family Advisory Board. I'm wondering, under your leadership what can you do to bring the Advisory Board back to life? I'm glad to see the diversity in your program. I'm glad you are serving the African American community very well. Bayview has a more diverse population now.

Ms. San Miguel: We work with all different groups, including the Russian, Bosnian, Native American communities. We also have children and families who decline to state their background because they consider themselves multi-racial. Our client population is 50% African American and 14% Latino. The Asian Family Mosaic program is run by RAMS (Richmond Area Multiservices.) We also have Asian families in the Bayview.

Ms. Echavarri: CSOC has a similar breakdown.

Ms. San Miguel: The Advisory Board was one of the things I asked about when I was hired. Under this new SAMHSA grant we are considering having the Family Council serve not only FMP but also intensive case management in general. We are wanting to pool our resources and have a unified Parent and Youth Council and then have our providers involved.

The late doctor Patricia Evans was very much involved with the parents. When Dr. Zomalt left the FMP, there were a lot of vacancies in the agency and the advisory group was something that was left behind.

We'll be doing a joint open house in the fall and will invite you. CSOC and FMP are located in the same building now, which makes it easier to work together.

Dr. Moses: The FMP Advisory Board was very helpful, so I think this is a good idea to restart the Council.

Ms. Knight: Thank you for coming. I was on the FMP Family Board with Cynthia in the 1990's, and so glad to see her commitment still going so strong. One of our big concerns at the time was about families without coverage.

Mr. Purvis: Are you working with AASCEND (Autism-Asperger's Syndrome Coalition for Education, Networking and Development)? Is that included in the scope of your work?

Ms. San Miguel: I'm not familiar with that agency. But I'll be glad to find out about it and follow up and let you know what happens. Consuela will be appearing in an upcoming interview on the Dean Edell show. I want to thank her for participating in this.

4.0 DIRECTOR'S REPORT

4.1 Report from the Director of Community Behavioral Health Services

Dr. Cabaj: I met most of you at your Annual Retreat. The 2nd Wednesday of the month is the hardest night for me to meet with you since I am in Sacramento for a statewide meeting of the Governing Board of the State Mental Health Directors Association.

Budget is the number one issue. Right now the most troubling concern I have is the OMI Family Center. It's off the cut list but it is still potentially vulnerable. There is a motion at the Board of Supervisors to not allow the OMI to be on the cut list.

We think we have a balanced budget now. But things may change depending on the State. I was just in Sacramento today. It looks like the money for CSOC and AB 3236 will go into a realignment package. We haven't seen the details yet. And it could be good or bad for the county, depending on what it's tied to. Perhaps it will be tied to tobacco tax, but with smoking going down in the state, which we all want, that may mean funding trouble for these programs.

With regard to funding for special education, the State has not paid for the past year, and won't for the next year. But it is a mandated program. Several counties are opting out. One county sued and won the right to drop out. We don't want to follow that route because we think we provide very good programs to special education children.

(Dr. Cabaj distributed his written report.)

Budget Update. The Department has submitted a FY03-04 budget, which was approved by the Health Commission, and submitted to the Mayor's Office in February. The second step was to prepare a contingency plan of additional reductions for the Mayor to use in the event that his office was unable to balance the City's budget. The Department submitted a contingency plan totaling $39M of which $17M has already been taken to assist in balancing the budget, leaving a balance of $22M in potential future reductions. Of the $17m in reductions, approximately $3.6m in CMHS day treatment services were eliminated. The Department is considering these reductions to be permanent, pending any restoration of funding by the Board of Supervisors, and has requested contractors to provide transition plans, where appropriate, to detail the steps required to implement the changes prior to July 1. At this time it is not know how much more, if any, the Mayor's Office will require from the remaining $22m to balance the budget.

Office-Based Opiate Addiction Treatment (OBOAT). Heroin use creates serious health consequences and financial burdens on its users, their families, and communities. In 2002, San Francisco had between 15,000 and 17,000 active heroin users, with an opiate replacement therapy capacity of about 5,000. To increase opiate abuse treatment in San Francisco and counteract the shortage of treatment in the City, the Office-Based Opiate Addiction Treatment (OBOAT) Program was developed.

As a pilot program, OBOAT will provide methadone maintenance treatment and Buprenorphine for 90 patients in Potrero Hill Health Center, Tom Waddell Health Center (two public clinics), Julie Leavitt, M.D.(a private physician's office), BAART (a private clinic associated with an Narcotic Treatment Program), and the county jail in San Francisco. Methadone will be dispensed at San Francisco General Hospital (SFGH)

Outpatient Pharmacy and, after a brief induction period at a specialized clinic, Buprenorphine will be dispensed at the Community Mental Health Services Pharmacy. In addition, SFGH Opiate Treatment Outpatient Program (OTOP) will accommodate 10 slots for OBOAT patients or candidates for OBOAT patients who need to be stabilized and evaluated.

Carefully trained multi-disciplinary treatment teams including physicians, counselors, pharmacists, and administrative staff will assess individual patients' conditions and their needs, and also help them adhere to their treatment plans and improve their lives. Take home doses of methadone will be granted for patients who meet criteria specified by the State and Federal Licensing Agencies and the OBOAT program policies. Buprenorphine will be prescribed for patients whose physicians and counselors decide that it is a viable option. Performance of patients and providers will be carefully monitored and evaluated.

Information exchange among the team members regarding the patients will be carried out through a secure web based database custom-designed for OBOAT. For example, SOAP notes will be simultaneously shared among the treatment team members on the web-based database. This will help providers meet the needs of the patients in a timely manner and coordinate/develop multi-disciplinary treatment plans.

Training for OBOAT is comprised of three parts: a one-day overview training, practicum training at the sites, and a training at OTOP. The first all-day training, conducted by the California Society for Addiction Medicine (CSAM), was held on July 11, 2002. Individuals who were unable to attend and physicians wishing to receive their Buprenorphine certification attended the second training on January 22, 2003. The practicum trainings have been ongoing and additional training sessions will be planned in May 2003. In addition, the OBOT database will be fully functional in May. Implementation staff members expect the OBOT program to be licensed by the Federal and State governments within a month. Once this program is fully implemented, it will reduce the burden created by heroin use in the City of San Francisco.

Advanced Access. CMHS initiated Advanced Access in November of 2002 with the goal to eliminate delays in accessing CMHS adult outpatient services. Three different types of delays have been virtually eliminated as a result of this initiative. These are delays in intake appointments, first psychiatrist appointment, if needed, and any follow-up appointments. Average wait time for intake appointments used to be approximately three weeks, which has now been reduced to less than 48 hours. The Pharmacy Services developed a new protocol for new and inactive clients to obtain medication the same day as the intake. The Children's Services section has since initiated its own advanced access initiative and we will report on that at a later date. More details of Adult Services' Advanced Access initiative can be found at the website www.sfadvancedaccess.org which is maintained by the Quality Management Unit.

The data on average system-wide delays for adult services is as follows:
1st interview for new clients: 2 days
1st medication evaluation for new clients: 7 days
1st medication support following evaluation: 6 days
1st follow-up for treatment following evaluation: 5 days

Used this partially in Kaiser and in LA which is the program we went with, Children's to embark on it.

Dr. Cabaj: When we initiated Advanced Access the clinics said it couldn't be done. The average wait was up to 8-9 weeks. Our goal was to get the wait down to 24 to 48 hours. The sooner you see someone the better, or if medicine makes a difference, the sooner you start, the better.

The results have been very exciting. We started in February and staff were complaining to me. They swore this would never happen. I said, let's give it a try. Let's just see. Linda Wang was very patient with everyone. Tom Mesa helped with the implementation. It's working. Everyone is excited about this. The Health Commission is excited about this. Los Angeles is now looking at our experience to learn from us. We'll be applying this to the substance abuse clinics next.

IMD Alternatives for African American Clients. San Francisco Community Behavioral Health Services received notice at the end of April of a grant award for developing community alternatives to Institutions for Mental Disease (IMDs, i.e., psychiatric locked facilities). San Francisco and Merced Counties were the two counties selected for grant awards. SFCBHS applied for a grant over a year ago, responding to a request for proposals issued by the State Department of Mental Health. The grant of $399,444 is for each of two years, and will provide the opportunity to develop a model of culturally competent strategies to successfully transition African American clients from IMDs to community settings and to develop an intensive case management team to work with this target population. A review of data of locked psychiatric long term care facilities treating San Francisco clients indicates that a disproportionate number of African American males are placed in these facilities, that they stay longer, they are harder to place in the community and they recidivate faster. We are very pleased at this opportunity to develop approaches to help African American clients more successfully return to community living.

Earn While You Learn Workshops. Community Vocational Enterprises (CVE) and the Mobile Support and Treatment Team Homeless Integrated Services Project (MOST AB 2034) are engaged in a unique and innovative collaboration that provides paid training and vocational development for MOST AB 2034 clients. These clients are all seriously mentally ill, with histories of homelessness. Prior to enrolling in the MOST program, they had been treated in acute psychiatric and medical services or had arrest histories, but they had not linked with community based mental health programs. Many have little or no employment history.

Over the past two months, CVE has been facilitating interactive workshops for a group of eight MOST AB 2034 clients, exploring work related topics such as goal setting, communication, stress management and receiving feedback. The sessions are held twice a month, and the participants are paid stipends of $10 per session. As an incentive for consistent participation, participants who attend both sessions for the month receive a $5 bonus. The groups are facilitated by Anne Miles, CVE's Occupational Therapist, and by Jen Carney, CVE's Vocational Intake Specialist. Additional support is provided by Russell Berman from the MOST AB 2034 team.

The participants have been inspirational, attending consistently and exploring topics with much self-reflection and understanding. The group has developed a supportive dynamic, with the participants showing spirit and good humor! The collaboration is intended to familiarize the MOST AB 2034 clients with the programs and staff of CVE, so that the transition of the participants from the training program to initial employment in one of CVE's transitional businesses goes smoothly and successfully. So far, it looks like a winner-participants are expressing interest in employment assistance. More information about the collaboration can be obtained by calling Stephen Poulin, CVE Program Director, at 544-0424 ext. 107, or via email, at spoulin@cve.org.

Peg Hickox, RN, MSN. Peg Hickox, RN, MSN, Program Director for the OMI Family Center, was honored by the San Francisco Board of Supervisors on May 6, 2003 with a certificate of honor publicly recognizing outstanding service to people of the City and County of San Francisco. Ms. Hickox was commended for commitment to nursing and serving mental health patients as the Director of the OMI Family Center in recognition of Nurses' week and for being an inspiration to all.

Michele Friedman, BSN. Michele Friedman, a Program Analyst for Community Programs, and formerly the Director of Quality Improvement for Community Mental Health Services, was one of 29 nominees for the first O'Connell Society Award for Advancing the Profession of Nursing 2003. Michele was one of three finalists for the award.

Dr. Cabaj: One thing that didn't get in the written report was undercover reporting done by Channel 5. I was pretty upset about this. They sent a reporter disguised as a "psychotic using cocaine." Cameras were sneaked into five of our clinics. Channel 5 is going to do an exposé. They showed the tape this morning to Mitch Katz and Linda Wang. The Mayor's Office is outraged. They visited three of the clinics at lunch time. A few had their doors closed because they are so short staffed.

Dr. Katz videotaped comments. The City Attorney is involved because Channel 5 filmed clients, breaking confidentiality. I don't know what the point is for the piece. But if they make the point that more cuts will make things worse, it's going to be useful. I'm hoping we can make lemonade out of lemons.

Another thing of concern is the Mental Health Rehabilitation Facility (MHRF). Everything changes by the minute. Right now, as you probably read in the press, the MHRF may stay open as the MHRF.

There are 50 clients who should be in a lower level of care and there is no place to send them. The 20 clients who were transferred have all agreed or their conservators or family members have agreed. They have been transferred to programs that added a special care need. And if it makes sense to transfer them back we'll do that.

The union has caused the State to come to the MHRF on a daily basis. They have been whistle blowing every possible incident and making life tough there.

We don't know if the MHRF will go back to what it was or if we can re-design it. I would like it to be a mixed license unit. We don't need more than 50 some beds in the locked part of the facility. We really need more residential programs. Probably the MHRF will stay as locked facility. But I don't know how large.

The MHRF is run by San Francisco General. The doctors report to me, but otherwise the MHRF is run by SFGH. And the hospital staff first suggested this change. The deal with the union is still not finalized, so things could still fall apart. I feel badly for the clients and the staff there, because things are constantly changing.

Dr. Moses: We're glad to have you back. We are very concerned about MHRF. I'm glad things are moving in a positive way. This Board was very instrumental when the MHRF first opened.

I hope you can take an active role in protecting programs in the Bayview Hunter's Point. I'm glad you have addressed the needs of the African American population. I'm hoping that some of this money can be used to hire African American staff to run this program.

Dr. Cabaj: If all goes well, I think you'll be very happy with my selection for a medical director, but I won't know about that for 3 weeks. We may end up working more directly with running the medical side of the MHRF.

Ms. Knight: Regarding the possible closing of OMI, I have had a personal relationship with OMI over the last ten years. It's a great place for families, and they have great interns. The staff are long time civil servants, many with 20 years of experience. I myself have 30 years with the City, and this is the worst budget time I've seen. I received great service from OMI. I would really hate to see OMI close, because of the dedication of the staff. It would be a tremendous loss.

Dr. Cabaj: We went to OMI when this started happening and said to alert everyone. And they have done that. There is now a resolution at the Board of Supervisors to keep the OMI Family Center off the cut list.

At least 136 children are followed there in special education. I also house my Transitional Youth Psychiatrist there and I would not want to have to relocate him. I really don't think OMI is going to get on the list again.

mr. martin: I want to express appreciation that you could make it here tonight. I found out about 4 p.m. this afternoon that Supervisor Daly is going to Sacramento tomorrow to advocate for funding. We started calling around to see if we can make our efforts resonate with what the City lobbyist is doing. What we heard is that the City lobbyist has not made any efforts to protect mental health money at the state level.

Dr. Cabaj: We have been concerned about the AB 3632 and CSOC funding. But if you hear anything more let me know.

Ms. Leung: What about Advanced Access?

Dr. Cabaj: If you have an 8-week waiting list, then when you walk in on Monday morning, you're doing the work of 8 weeks ago. The idea is to do today's work today. If you are seeing people today, who applied 8 weeks ago, you also get a big no show rate. This outraged me, not to be using those hours to see clients.

So we drained the backlog by temporarily adding staff time and backfilling vacation time. We caught up on the people waiting and in 6 weeks, got every clinic to catch up on all past waiting lists. We moved from 8-weeks-ago work to today's work.

Ms. Leung: At the MHRF you said you only need 50-70 beds. I think the criteria need to be reviewed. I have a patient who has been hospitalized numerous times and I still couldn't get them into the MHRF.

Dr. Cabaj: You make a good point. One part of what was supposed to happen was to pull together a clinical review before the budget crisis. The Mayor is now going to appoint a Blue Ribbon Panel to look into the MHRF.

I would like to compare the MHRF to other similar facilities throughout the state. It serves two major populations now: 1) people who have been there a long time and 2) the people leaving the SFGH inpatient wards.

One idea might be to have 90-100 beds in the locked part of the facility, plus another 50 for residential.

Mr. Luebkeman: I think the realignment idea could be disastrous for care, not so much in San Francisco, but in other counties around the state. Will that take place? My understanding is that it was supported by the Vehicle License Fee (VLF), and I read that the governor has agreed to raise the VLF. Is anyone working actively against realignment, including everyone in our own state delegation? And could you step us through the clinical criteria for admission to the MHRF?

Dr. Cabaj: The criteria for the MHRF are changing. I don't know what the latest criteria are. Basically admissions have been on hold to the MHRF for the last couple months. For the most part people have found other alternatives. Also during that time some of the ADU beds had to close down because of bed bugs, which put moe pressure on the MHRF.

Mr. Luebkeman: What were the criteria 4 months ago?

Dr. Cabaj: The newest clients were coming from acute care units and were needing more time to stabilize and learn more about getting back into community. The old concept for the MHRF was rehabilitation. Mostly those kinds of clients weren't coming in anymore, like the clients who originally came from Napa. I wanted a clinical program that accommodated the recovery model more, and would make better use of our community resources. The hope was no one would be there longer than six months. Three months is what we hoped for. Many people were moving through and not coming back. When clients did come back, it was for a particular clinical issue. For example, some came back because they didn't want to leave and didn't feel safe in the community.

Realignment is a very mixed bag. Realignment I is what supports most mental health in the counties. Funding levels were never adequate, and it was a pool that we dipped into with three other programs and the other programs were getting more, such as In Home Supportive Services and some of the health programs.

With Realignment II now, the same worries are there. Are they going to give us a base that's adequate and can the fund grow over time? How mandated will it be? Or will the state be able to shift the money to something else? How much control will we really have? We need to see the details.

The County Directors have been against realignment. Tomorrow they will be debating the proposal. If it's tied to a new tax, the Republicans have said they will not pass a new tax.

Member of the public: I live in a co-op. If you know you need residential beds, why not make that happen instead of returning to locked facility? There are a lot of clients who have no where to go.

Dr. Cabaj: That's a very good point. I wish we had full control over the money. I would like to do a mixed unit. We need some locked facilities, and it's better to have them be in San Francisco. Right now it's a decision that the Mayor is working on with the unions. So it's not focused as much on clinical needs.

4.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: We completed the 5th Police Crisis Intervention Training. The next one will take place July 21-24.

5.0 MENTAL HEALTH BOARD COMMITTEES

5.1 Report of the Chair of the Board and Executive Committee
Mr. Stinson: The theme this year for our Reception is bringing together the various advisory and advocacy groups. This ties into the theme of integrating mental health and substance abuse. We've gotten lots of positive response so far.

Ms. Leung: Evelyn Lee was the Executive Director of RAMS. and passed away recently. I wonder if we could note her loss to the community. I think it would take four people fill her shoes. Dr. Cabaj: The Health Commission did a special acknowledgment to Evelyn Lee. We held a special training for primary care doctors on mental health issues and dedicated the training to her memory. Also the San Francisco Mental Health Contractors Association is making a special donation to RAMS.

Mr. Stinson: Dorothy agreed to co-chair a joint Program and Services and Children's Committee with Carol. We want to create opportunities for Board members to get involved in issues outside of our Board meeting. Dorothy and Carol will do a fantastic job co-chairing this committee.

Mr. Leubkeman: At the time that I offered the following resolution, we were in the thick of the war in Iraq. I've had experience with friends and acquaintances who were

devastated by their war experiences in Vietnam. I believe that when you serve your country, the Veterans Administration should be there for you when you come back. And the federal government should do this instead of leaving it to the cities.

Dr. Del Zotto: I think this is very important. I think we need to be there for our young people. We owe it to them to help them heal when they come back from their experience.

PROPOSED RESOLUTION (MHB-2003-13): ENSURING QUALITY PHYSICAL AND MENTAL HEALTH SERVICES FOR OUR RETURNING SERVICE PEOPLE.

WHEREAS, tens of thousands of young people from the United States, both citizens and non-citizens, along with veteran officers, are now engaged in military action in Iraq, and will continue to be engaged in Iraq following the end of armed conflict, and

WHEREAS, many of our service people have partaken in fire fights and have had to kill people for the first time in their lives, and whereas they have been witnessing death and destruction on a scale they have never before experienced, and whereas they have been and will continue to be subjected to extraordinary stress and danger, and

WHEREAS, in past wars and incursions, the U.S. military and Veterans Administration have not always responded adequately to the physical and mental health issues of service people, now therefore,

BE IT RESOLVED, that the Mental Health Board urges the City and County of San Francisco and San Francisco's Congressional delegation to take what steps they can to make sure the Veteran's Administration and the Department of Defense meet the physical and mental health needs of our returning service people immediately with comprehensive, quality services, which are also culturally competent. (Passed unanimously.)

6.0 NEW BUSINESS

Dr. Moses: Last week the Mayor sent out letters to all the Boards and Commissions to attend a Sunshine Training. I was wondering if the City Attorney can give us the videotape that they use to do that training. And if we could ask for a Deputy City Attorney to come to our meeting.

Mr. Kalman: This Board respects very much the sunshine requirements. Thank you.

7.0 PUBLIC COMMENT

Mr. Kalman: The Recreation and Parks Department is supposed to have programs for people with disabilities. Can we check on what they have for the coming budget year? Is someone from the Board participating in the Mayor's Disability Council activities? They are concerned mostly about physical disability problems.

mr. martin: I'd like to respond to that. I've done a lot of work with Susan Mizner at the Mayor's Council on mental health issues. Barriers are not just physical, there are a lot institutional barriers in place. And they've done a lot of work on that. They've had hearings specifically about those issues.

Mr. Stinson: Tonight we'd like to adjourn our meeting in memory of Dr. Patricia Evans. I'd like to ask Carol to say a few words about her.

Ms. Knight: Dr. Evans was the Medical Director of Maternal and Child Health for the Department of Public Health. For me she was a friend and a mentor. She took the time when I was in my internship at San Francisco State University to listen to what I had to say. I'm grateful for her kindness and her patience. She supported me in a program that I started at Community Focus. She was a wonderful friend. She died unexpectedly on April 19th. She wrote a letter of reference for me when I was applying for the Board which I think gave me the opportunity to serve on the Board. She was very special.

Mr. Stinson: We now adjourn our meeting in memory of Dr. Patricia Evans.
(The meeting was adjourned at 8:40 p.m.)

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, June 11, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of May 14, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 11, 2003, to the following members: Sandy Yuen

2.0 PRESENTATION: REVENUE COLLECTION AND ENHANCEMENT FOR MENTAL HEALTH (50 minutes)

Michelle Ruggles, Director of Operations, Community Behavioral Health Services

30 DIRECTORS REPORTS (30 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

4.1.a. PROPOSED ACTION: Be it resolved that the Mental Health Board proposes a special commendation for Officer Mike Cowhig for his work as psychiatric liaison. (Attachment A)

4.2.a PROPOSED ACTION: Be it resolved that the Mental Health Board proposes a special commendation for Supervisors Daly and Maxwell for taking a busload of advocates to Sacramento on May 15, 2003. (Attachment B)

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

MENTAL HEALTH BOARD
ATTACHMENT A
June 11, 2003

Since 1998, Officer Mike Cowhig has been the Psych Liaison for the San Francisco Police Department. We couldn't have asked for anyone better. He has been a tireless advocate for the mentally ill. This has not been just a job for him, but a mission. He has made such a difference for mentally-ill people who have come in contact with the police.

Mike will be leaving his position this summer to work in the Employee Assistance Program of the Police Department. We will miss him tremendously.

RESOLUTION (MHB-2003-xx): TO HONOR MIKE COWHIG
Be it resolved that the San Francisco Mental Health Board present the following certificate of appreciation to Officer Mike Cowhig:

The Mental Health Board of San Francisco is proud to honor:

Officer Mike Cowhig
Psych Liaison, San Francisco Police Department

For your heartfelt commitment to the safety and well being of the mentally ill and their families.
For your dedication to supporting your fellow police officers, and for answering your pager at all hours of the day and night.
For the difference you made in the day-to-day working relationship between the Police Department and the Department of Public Health, just through the force of your personality.
For your incredible perseverance, your remarkable way with words, and your unfailing personal warmth.

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MENTAL HEALTH BOARD
ATTACHMENT B
June 11, 2003

RESOLUTION (MHB-2003-xx): APPRECIATION FOR SUPERVISOR CHRIS DALY AND FOR SUPERVISOR SOPHIE MAXWELL

WHEREAS, the City and County of San Francisco is facing the most serious budget crisis in many years, and

WHEREAS, this budget crisis threatens to do permanent damage to the City's public health and human services infrastructure, and

WHEREAS, the decisions made by the Governor and the state legislature will have a very significant impact on the future of services in San Francisco, and

WHEREAS, on May 15, 2003, Supervisor Chris Daly and Supervisor Sophie Maxwell took a busload of dedicated activists and City leaders to Sacramento for a day of high-powered advocacy on behalf of services which are so desperately needed by our city and its most vulnerable citizens, now, therefore

BE IT RESOLVED, that the San Francisco Mental Health Board expresses its heartfelt gratitude and appreciation to Supervisor Chris Daly and Supervisor Sophie Maxwell for their action-oriented approach to the budget crisis and for their steadfast and inspiring leadership.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

UNADOPTED MINUTES
Mental Health Board
Wednesday, June 11, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; Dorothy Shaffer, R.N., N.P., M.S.N.; Idell Wilson.

BOARD MEMBERS ON LEAVE: Jay Golub; chance martin; Kate Walker; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: Toye Moses, Ph.D., M.P.H.

PRESENTERS:
Michelle Ruggels, Director of Operations, Community Behavioral Health Services

OTHERS PRESENT: Bill McConnell, Ph.D. (Community Behavioral Health Services); Minister Sandra B. Norshaka (A.C.A.); Jeanel (John) T. O'Connor; Rebecca Turner (Alliant International University); Phoebe Kwok; Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

A quorum was not present until 8:15 p.m. No votes were taken before that time.

Mr. Stinson: Idell has been serving on the Safe Haven Task Force. It's a wonderful example of how we as members of the community can get involved in policy issues.

Ms. Wilson: The Safe Haven program is to allow for women to drop off newborns at the city's fire stations if they don't want to keep their babies. The theme is: "No shame, no blame, no name." The committee did some brochures and put out some commercials. They did a press conference. Next they will be distributing the brochures out to the community. This is a good law and a good program.

Member of the public: Who takes these children? Ms. Wilson: They are dropped off at a fire station, then the Department of Human Services comes in and takes over from there. Then the baby is taken to foster care. Because of this law, women will drop off babies rather than leaving them in the trash. And the women are not penalized.

Mr. Stinson: How did you get involved in the Task Force? Ms. Wilson: Helynna got me involved. We went to the Board of Supervisors to testify and they asked me to join.

2.0 PRESENTATION: REVENUE COLLECTION AND ENHANCEMENT FOR MENTAL HEALTH

Mr. Stinson: The presentation tonight is in response to a resolution we passed several months ago. We want to look at how revenues are collected. This is a very important aspect of the system. Ms. Ruggels is the Director of Operations for CBHS, and she was on Harvey Rose's budget staff.

Ms. Ruggels: The key question we'll be looking at is: How do we know we are maximizing our revenues and how do we know we are doing our billing correctly?

CMHS Revenues and Expenses:

REVENUES 02/03		
Health/Welfare sales tax	43,827,251	Re-alignment money is from the State.
Health/Welfare VLF (Vehicle License Fee)	11,498,449	There are minimal strings attached, so we get to decide how we spend it.
Realignment subtotal	**55,325,700**	
CMHS revenues	11,712,684	From the State
Short-Doyle Medi-Cal	35,732,144	
State-mandated costs	1,385,361	
Misc. fees	806,739	
Patients Payment	270,000	Client's payments or their insurance
Medi-Cal	7,905,237	
Medicare	600,000	
Subtotal	**58,412,165**	
Work orders	**9,684,220**	From other departments, mostly for children's services.
Grants	**5,657,458**	Such as SAMSHA and other federal grants.
County General Fund	**37,345,119**	City & County of San Francisco
GRAND TOTAL	166,424,662	

EXPENSES 02/03

A. Salaries + MFB	
General Fund	43,038,203
Work Orders	701,543
Grants	2,937,220
Subtotal	0
	46,676,966
B. Contracts	
General Fund	97,914,790
Work Orders	8,934,584
Grants	2,297,675
Subtotal	**109,147,049**
C. Maintenance, Equipment, Rent, Other	
General Fund	7,590,456
Work Orders	48,093
Grants	343,063
Subtotal	**7,981,612**
D. Service by other depts.	
General Fund	2,539,535
Work Orders	0
Grants	79,500
Subtotal	**2,619,035**
Totals	
General Fund	151,082,984
Work Orders	9,684,220
Grants	5,657,458
GRAND TOTAL	**166,424,662**

Notes on Revenues:

Work orders are requests from other City departments for services from CMHS, and these are mostly children's services. For example if a foster care child needs to see a clinician, then the Department of Human Services gives us the money to pay for those clinical services.

We have grants, like our annual grant from SAMHSA (Substance Abuse Mental Health Administration) and other federal grants.

If we get more revenue than we have expenditures, we can keep the difference, but we can't spend it unless we get a supplemental approval.

Notes on Expenses:

We give other departments work orders for services we need from them. For example, we pay the City Attorney for some services.

How do we get the revenues? How does this work? What follows is a simplified explanation. We have two ways we provide services. We have our nonprofit agencies which we contract with. And we have our civil service clinics. We take all the costs and divide them by the units of service each program will provide, and this gives us a cost per unit of service. Which in turn gives us the rates we use.

When a client shows up at a clinic, there is an assessment that is done to determine if the client has any ability to pay for any part of their service, or if they have insurance. When the client is seen by a therapist, the therapist writes down the information, which is then entered into our computerized billing system. At the end of each month we send a claim to the State. We also do that with the insurance companies.

We're the safety net, so we're not turning people away. But we do try to get a reimbursement if we can. We do a final reconciliation at the end of the year.

How do we know we are maximizing our revenues? We try to be very aggressive about this. We have a lot of systems in place. It used to be that if we had a Kaiser client seen in the Emergency Room, we'd send the bill and if they only paid half, we wouldn't pursue it, but now we do. We do trainings for our staff on how to do Medi-Cal billing. Day treatment and group services are billable but socialization is not.

How do we know we don't have problems with our billing? There was an article in the Bay Guardian saying that revenues were not being claimed and money was being missed. How do we know that there is not a stack of claims sitting in someone's drawer? Our contractors provide us a monthly invoice. And then we pay them in response to that invoice. In the past we just paid one twelfth of their whole contract each month. Now we reimburse only the units of service delivered during the month. So this is an incentive to report.

We can also look at productivity by clinician. All the clinic directors get reports so there is the potential for clinic directors to get involved in the process.

One of the areas we can improve is getting more people approved for Medi-Cal. This is our biggest potential for revenue increase. The federal government matches 50% of what we spend. So if we can come up with the base amount, it's a good deal.

When we start combining mental health and substance abuse services, it will be even more important to make sure we get Medi-Cal approved for every eligible person.

The federal dollars for Short Doyle go through the State and we claim it through the State. But the Medicare is from the federal government. The paper work is more difficult. There is more physician oversight required.

Mr. Stinson: How does San Francisco's revenue compare with the revenue of other counties? Ms. Shaffer: What can we learn from how other counties collect revenue?

Ms. Ruggels: In terms of the bigger numbers, Los Angeles and other counties have a lot of the same revenue categories. But there are competitive state grants like AB 2034 but not everyone gets one of those grants.

Maria Barto of the billing unit goes to state meetings where these issues get discussed by the county representatives. And she has discussions with other counties directly. So they try to help each other.

When new State funding comes up, it's not unusual to do a survey of what other counties are doing. And a lot of our billing people have been here a long time, and know their counterparts in other counties.

Dr. McConnell: California is relatively low in terms of the federal dollars it collects for mental health. And within the state there is a big difference between what different counties got. San Francisco was one of the counties to build mental heath services early.

Member of public: What kinds of federal grants do you get? Ms. Ruggels: For example, we get money from the federal Substance Abuse Mental Health Services Administration (SAMHSA). This is an annual grant. We submit a report of the expenditures at the end of each year.

Member of the public: Are there limits on how much of Medi-Cal services a person can use? Ms. Ruggels: As far as I know there is not a limit.

Ms. Shaffer: At some point you're going to get a case manager if you're using a lot of services. Ms. Ruggels: We set up SPR's (Single Point of Responsibility programs), which are intensive case management programs, with a total of 400 clients. The clients who were eligible were those using over $100,000 per year of expenses. The SPR's have reduced that cost significantly.

QUORUM NOTE
A quorum was present at 8:15 p.m. and the meeting was officially called to order at that time by Ted Stinson, Chair of the Board.

1.2.a RESOLUTION (MHB-2003-14): Be it resolved that the minutes of the Mental Health Board meeting of May 14, 2003, be approved as submitted. (Passed unanimously.)

1.2.b RESOLUTION (MHB-2003-15): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of June 11, 2003, to the following members: Rose Chung for Supervisor Aaron Peskin; chance martin; Kate Walker; Sandy Yuen; Dennis Yun, M.S.W. (Passed unanimously.)

3.0 DIRECTOR'S REPORT

3.1 Report from the Director of Community Behavioral Health Services
Mr. Stinson: Reporting for Dr. Cabaj tonight is Bill McConnell, Associate Director for Quality Management for CMHS. Would you tell us some about Quality Management along with the Director's Report?

Quality Management focuses on keeping the quality high in the system. We run the reviews of programs every year. We run the incident reporting system. When something bad happens, there's a requirement that it gets reported to us, and we investigate. We do medication monitoring, tracking the prescriptions of doctors to make sure the pattern makes sense. We do chart reviews to make sure the documentation for billing is there.

I talked to Helynna about making a more general presentation about Quality Management. We decided to do that after integration of CBHS is further underway.

The written Director's Report was distributed:

Budget Update. Mayor Brown released his proposed $4.8 billion FY 03-04 budget to the Board of Supervisors last week. The budget absorbed the $347 million deficit faced by the City and avoided many of the prior anticipated cuts. As union members voted to pick up the 7.5% employee share of retirement, many additional cuts were avoided and $2.0 million in General Fund moneys were restored. The restored funds were used for adult dental services, and various mental health and substance abuse programs. The mental health services restored include the Bayview Hunters Point Foundation-Thunderseed Day Treatment Program and the Progress Foundation–Rypins/Carrol residential and day treatment programs.

The Board of Supervisors is currently reviewing the Department budget. The Department's budget hearings will be held on the Thursdays of June 12th and June 19th. The hearing for public comment will be held on June 11th.

At the State level, due to the Federal enactment of the "Temporary State Fiscal Relief" bill, the Davis Administration (Department of Finance) was able to restore many proposed cuts, including the proposed reduction of 10 percent provider rate reduction for the inpatient and outpatient managed care programs. This is good news, as these programs were already cut to address citywide budget issues.

Caring Partners Program. CBHS Pharmacy has come to an agreement with AstraZeneca Pharmaceuticals to participate in their "Caring Partners Program" for our qualified indigent clients. Under this agreement, the pharmacy receives at no cost, on a monthly basis, a supply of the antipsychotic drug Seroquel approximately equal to the amount dispensed to our indigent clients during the preceding month. This represents a cost avoidance of $28,298.

Stigma Psychoeducation For African American Mental Health Clients. UCSF Researcher Dr. Jennifer Alvidrez has just received a grant from NIMH to develop a psychoeducational intervention to reduce stigma concerns among public-sector African

American psychiatric inpatients that have been referred to outpatient mental health services. The intervention protocol will be developed in consultation with African American consumers as well as providers and consumer advocates who work with the population. Dr. Saumitra SenGupta from the Community Behavioral Health Services will work on this project as a co-investigator.

Ms. Shaffer: Is this study for adults only, both male and female? Dr. McConnell: Yes. Her study is in two parts. First, there is a series of focus groups to decide what the psychoeducation should be. Then part two is to carry out the education program. It's very client-oriented.

Ms. Shaffer: What does the term psychoeducation mean for you? Dr. McConnell: Psychoeducation is a very specific term for us. It involves educating people about their illness and medications.

Member of the public: In your function as Quality Manger are you working with a committee or board or group? Are you more than a budgetary committee? Are you an investigative committee? Dr. McConnell: It's a section of the administration of CMHS.

Member of the public: If I'm a client and I have experience of abuse in the system, is your group the one to go to about that? Dr. McConnell: Yes, we have a grievance procedure.

Mr. Douglas: How many people are in your section? Dr. McConnell: Nine, plus two in medical records.

Mr. Kalman: Is the Mayor's budget identical to what the DPH submitted? How should we approach the Mayor's Office or the Board of Supervisors? Should we use the Mayor's budget book?

Ms. Brooke: That budget that the Mayor prepared went to the Supervisors on June 3rd, and the Board has until the end of June or early July to make some adjustments. They don't really have any more money.

Mr. Kalman: I'm raising these issues because we see different figures in the newspapers. Who knows how they get their figures? The Controller has another set of volumes which are printed. It's about twice as thick as the Mayor's budget for the whole city. But did someone compare what was proposed by DPH with what's in the Controller's report and the Mayor's budget?

Minister Norshaka: I'm part of the African Community Council. I have several hundreds of our community residents in Western Addition and Bayview, who are concerned about some of the clinicians and confidentiality, specifically that their privacy is being violated, that some of the things they are sharing in therapy are leaking out to other staff in the offices.

We also have concerns about client-to-client safety.

We have concerns about the safety of children going to counseling sessions. It's become a crisis in our community.

My daughter was raped and molested in foster care in 2001. Her therapist was at the Southeast Child facility. The therapist was informed and didn't do anything about it, because the Department of Human Services was part of the abuse. What accountability does your agency have when it is another City Department involved in the abuse?

Dr. McConnell: I want to follow up with you. We are accountable for what happens. I think we should talk.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: Thank you to everyone on the Board for reviewing the managed care contract between CMHS and the State. If you have any questions you can ask them of Dr. McConnell.

We have one slot open for the training for mental health staff at the Police Academy. The training is designed to help us understand the police point of view.

Supervisor Bevan Dufty has asked to be appointed to the Board of Supervisors Seat on the Mental Health Board.

Ms. Leung: Responding to what Minister Norshaka said, I would like to hear more what the community concerns are. I believe this is part of the Mental Health Board's responsibility to make sure that those in need get what they need. I'd like to know why someone got raped and there was no intervention.

Mr. Stinson: We have to strike a balance between not being an investigative body, and at the same time, being a body that does have some influence with various entities in the City. If there is something that is going on that's wrong, and it seems it is being ignored by the system then something needs to be done. I don't personally know what the right vehicle is. I think that grievances should go to the system first.

Ms. Brooke: As new business a Board member can ask that the Board look into the issue.

Ms. Leung: I am concerned about this. I wonder if on the personal level or Board level, if we would have a chance to hear more about this.

Ms. Shaffer: We could ask for reports on the incidents. And if there are certain patterns or trends what are the recommendations about what to do about that. And can we make sure that all consumers are being given information about the grievance procedure?

Mr. Douglas: There's also a private nonprofit that does advocacy in the public mental health system, namely Clients Rights Advocates. We might get them to speak to us.

Ms. Shaffer: That's an excellent idea.

Mr. Stinson: What I'm hearing is that we should have Bill McConnell back to talk about Quality Management. And part of that discussion should be how we as a Board can take

in feedback from the community about how the services are provided. And then we need to make sure we do that in a fair way.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

Mr. Stinson: Thank you to the Board members who attended our Annual Reception last month. Two Supervisors attended: Supervisor Fiona Ma and Supervisor Jake McGoldrick, and two mayoral candidates: Angela Alioto and Tony Ribera. Over all it was a success. One of the things I personally find the most satisfying is meeting with our Supervisors and talking with the people who are making the decisions. They appreciate our input and our perspectives.

I'd strongly encourage you to keep in contact with your Supervisor. You can work with Helynna to schedule an appointment with your Supervisor. Ms. Brooke: I have calls into each Supervisor to schedule meetings.

RESOLUTION (MHB-2003-16): TO HONOR MIKE COWHIG
Be it resolved that the San Francisco Mental Health Board present the following certificate of appreciation to Officer Mike Cowhig:

The Mental Health Board of San Francisco is proud to honor:
Officer Mike Cowhig
Psych Liaison, San Francisco Police Department

For your heartfelt commitment to the safety and well being of the mentally ill and their families.
For your dedication to supporting your fellow police officers, and for answering your pager at all hours of the day and night.
For the difference you made in the day-to-day working relationship between the Police Department and the Department of Public Health, just through the force of your personality.
For your incredible perseverance, your remarkable way with words, and your unfailing personal warmth.
(Passed.)

RESOLUTION (MHB-2003-17): APPRECIATION FOR SUPERVISOR CHRIS DALY AND FOR SUPERVISOR SOPHIE MAXWELL

WHEREAS, the City and County of San Francisco is facing the most serious budget crisis in many years, and

WHEREAS, this budget crisis threatens to do permanent damage to the City's public health and human services infrastructure, and

WHEREAS, the decisions made by the Governor and the state legislature will have a very significant impact on the future of services in San Francisco, and

WHEREAS, on May 15, 2003, Supervisor Chris Daly and Supervisor Sophie Maxwell took a busload of dedicated activists and City leaders to Sacramento for a day of high-powered advocacy on behalf of services which are so desperately needed by our city and its most vulnerable citizens, now, therefore

BE IT RESOLVED, that the San Francisco Mental Health Board expresses its heartfelt gratitude and appreciation to Supervisor Chris Daly and Supervisor Sophie Maxwell for their action-oriented approach to the budget crisis and for their steadfast and inspiring leadership. (Passed.)

6.0 NEW BUSINESS

Ms. Shaffer: Regarding children's mental health, I'm participating with parents on the community advisory committee on special education. I'd like to look more into how we collaborate with the school district.

7.0 PUBLIC COMMENT

Minister Norshaka: I wanted to mention an incident that happened in Stockton. The 15-year-old son of a friend of mine was molested by a mental health clinician. The son was taken by the clinician to the clinician's house. The child fought back in self-defense, but ended up being arrested. The clinician has since had a heart attack and died.

What is the screening process for clinicians? Do you check their religious background? This man was a part of a cult. Do you check on family background and mental health background?

Are you willing to come to the community and do a forum in each district so the people can share their concerns? We have eleven districts.

Member of Public: I'm a long-time consumer, and I'm applying for consumer seat on the Mental Health Board. I would like to have the chance to give my input which I've been trying to give in the past and it hasn't been received.

Mr. Kalman: I just picked up another document from the Controller's Office. It's on homeless services, saying the city lacks effective goals and plans for its homeless services. It's 70 pages. There is only one page about mental health issues. Do you have knowledge of this report and how it will be answered by mental health services? It's common knowledge that it's a desperate situation out there.

Member of public: Do you have a list of mental health board by-laws? Ms. Brooke: Yes. I'll be glad to get them for you.

There being no further business, the meeting was adjourned at 8:27 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, July 9, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of June 11, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 9, 2003, to the following members: Ted Stinson, Sandy Yuen

2.0 PRESENTATION: DIALETICAL BEHAVIOR TECHNIQUES WITH COGNITIVE MENTAL ILLNESSES (50 minutes)

Blanche Korfmacher, Assistant Clinical Director, Adult Services, Community Behavioral Health Services

30 DIRECTORS REPORTS (30 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee

The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

4.2. Presentation by Janice Cohen on Recommendations for Joint Advocacy Efforts Across Stakeholder Groups.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

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UNADOPTED MINUTES
Mental Health Board
Wednesday, July 9, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Augusta Del Zotto, Ph.D.; (Acting Chair); Bridgett Brown; Bob Douglas; Supervisor Bevan Dufty; Jay Golub; Carol Knight; chance martin; Toye Moses, Ph.D., M.P.H.; Joel A. Luebkeman; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Dennis Yun, M.S.W..

BOARD MEMBERS ON LEAVE: Andrea Leung, L.C.S.W., A.C.S.W.; Ted Stinson; Sandy Yuen.

BOARD MEMBERS ABSENT: Idell Wilson.

PRESENTER: Blanche Korfmacher, Assistant Clinical Director, Adult Services, Community Behavioral Health Services

OTHERS PRESENT: Linda Wang (Community Behavioral Health Services); Mike Wise (Voices At Bay Newsletter, San Francisco Network of Mental Health Clients); Janice Cohen, M.D.; Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was called to order at 6:34 p.m. by Dr. Del Zotto, Acting Chair.

Dr. Del Zotto: I'd like to welcome our newest Board member, Supervisor Bevan Dufty.

Supervisor Dufty: I'm here for you to teach me, so I can be an instrument for positive change.

Dr. Moses: I want to say a thank you to Supervisor Dufty for joining our Board. He's a very good friend, and very helpful to us in the Bayview Hunters Point. I represent him on the Delinquency Prevention Commission, so he's a good guy.

1.2.a RESOLUTION (MHB-2003-17): Be it resolved that the minutes of the Mental Health Board meeting of June 11, 2003, be approved as submitted. (Passed unanimously.)

1.2.b RESOLUTION (MHB-2003-18): **Be it resolved that the Mental Health Board grants leaves of absence for the meeting of July 9, 2003, to the following members: Ted Stinson and Sandy Yuen. (Passed unanimously.)**

2.0 PRESENTATION: DIALECTICAL BEHAVIOR TECHNIQUES WITH COGNITIVE MENTAL ILLNESSES

Ms. Korfmacher: How many people have heard of the diagnosis "borderline personality" disorder? Let me start with the official description of this diagnosis and how people make this diagnosis.

Diagnostic criteria for 301.83 Borderline Personality Disorder.

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

(5) recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feelings of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related, paranoid ideation or severe dissociative symptoms.

Not everyone with the diagnosis has all of these features, but generally have a lot of them. As you can see this is a difficult painful diagnosis. People who have it have extreme difficulty living in this world, getting along with other people, and getting along with themselves.

They have difficulty in regulation, such as emotional regulation and interpersonal regulation. So they often have chaotic relationships, have a hard time maintaining a friendship, or even more, an intimate relationship. They have self-dysregulation, meaning they are not sure who they are, they have a poor sense of self, and a sense of

emptiness. They have behavioral dysregulation, like suicidal behavior. Under stress they might act out. They might have cognitive dysregulation, including being paranoid or disassociating—not with themselves.

This is another way of looking at what happens to these folks.

What would be our rationale for launching into a major training program?

We haven't had very good outcomes using standard outpatient approaches. People with this Borderline personality diagnosis were frequently using acute services. Often they'd show up in emergency services. They were using a lot of hospital days or winding up in jail. Obviously this isn't helping the individual and it's hard on the system. There is a high cost to the system. We did an analysis, and found that the average cost to the system per person with this disorder is $18,000 per year. One individual alone cost $151,000 in one year.

mr. martin: Do the increased costs have anything to do with the fact that you can't qualify for SSI with borderline disorder?

Ms. Korfmacher: Possibly, that's a good question. But many of these people have a second diagnosis which qualifies them for SSI.

When staff are not getting the results they want, despite working very hard, they don't feel effective. And there is staff burnout. We wanted to find an approach that would be more effective.

Dialectical Behavioral Therapy is a comprehensive treatment for people with this disorder. It specifically addresses all those areas of dysregulation that I mentioned. It is a highly structured approach.

It starts with acceptance and change. Many of these folks have never been accepted by anyone. We start by helping the person feel validated and accepted. Yes, you are doing the best you can given what's happening right now. But it is possible to change and live a better life and develop the skills to address the issues you're facing.

There is individual treatment. Each person has an individual therapist, who will identify target behaviors, and help the person in a structured way understand what leads to those behaviors.

There is a group part of the program. It's more like a classroom than what we know as group therapy. They learn stress tolerance and emotional regulation. Some folks don't know how to handle stress effectively, so they wind up doing something disruptive to their lives and to others. It's the best they can do, but it's not effective.

They learn mindfulness, being focused in the present, being able to feel what you're feeling, and understand what you're feeling.

People get coaching during the actual times when they are in high stress, when they are likely to do one of those behaviors. They can call their therapist and be reminded what

it was they were going to do instead of cutting themselves or getting loaded. This is an excellent way for people to learn a new skill.

There is team consultation and support. Members of the treatment team meet on a regular basis and consult about the cases and provide support to each other.

There is case management if people need immediate help with housing and other areas.

The research has shown that this approach is the most effective treatment in reducing dysregulation behaviors, like suicidal behavior, and that the treatment gains maintain over time. There are fewer hospital days and social functioning improves.

Research has been done by the Linehan Group which developed this approach, as well as other independent groups.

The key goal is to help people create and maintain a life worth living according to their own core values.

Once people have mastered the basic areas, then the question is how can you get on with your life. We help people actually achieve what they want in those areas, such as schooling or relationships.

This approach can help people with this severe disorder actually graduate from the mental health system. And we haven't seen that happen before with the standard method.

We started working with Dr. Alan Fruzzetti, who is a professor at the University of Nevada. He helped San Mateo County launch their program, and they were very happy with him. He's done training with our staff. We've chosen a number of programs and developed teams. We already had one week of a two week intensive training.

We're training programs in both children's and adult systems. We had some SAMHSA funding and Children's System of Care funding that we combined to fund this whole training program. We're including staff from outpatient, residential, acute services, long-term services, the MHRF, intensive case management programs, and dual-diagnosis residential programs.

It'll take another year to get it totally up and running. We're pretty excited about this. And thankful that Dr. Cabaj and the Executive Team of Community Behavioral Health Services were supportive of doing this.

We'll provide continuing support and consultation. And we'll be developing a way to measure outcomes.

Dr. Moses: Where are most of your clients coming from?

Ms. Korfmacher: Pretty much citywide. I don't know the specific districts these clients are coming from. There tend to be more clients in the Tenderloin and South of Market areas in general.

Dr. Moses: Do you have clients from the Bayview Hunters Point area?

Ms. Korfmacher: The Bayview Hunters Point Foundation has a clinic on Third Street which provides services in that area, but they didn't decide to launch DBT in the first year. They may want to do this in the next year. We extended an offer to all of our programs to apply if they wanted to train. We hope once we get some successful teams going others will want to join in.

We're also training local trainers. We already had a couple of train the trainer trainings.

Mr. Luebkeman: Are there any organic origins to these disorders or brain chemistry issues like with schizophrenia? Are there any drug therapies that are helpful to this disorder? What are some examples of the skills you teach clients?

Dr. Cabaj: There's been a lot of research for decades on this disorder. At one time we thought it might be a mild version of schizophrenia. But that's not proven to be true. Some people medicate with anti-psychotics. Usually medications are not helpful. For some clients anti-depressants makes them more impulsive.

Ms. Korfmacher: What we're hearing is that people tend to be more medicated than we want. We want them to have all their faculties when they are engaged in this cognitive approach.

Mr. Douglas: How are clients screened into this program?

Ms. Korfmacher: All of the programs developing this DBT approach are setting up criteria for who is eligible. It's very much a voluntary program. We introduce people to it, then it's up to the individual to decide. There's a lot of work involved.

To be effective it takes at least one year to get to the point where people are significantly changed and moving toward life goals.

Ms. Shaffer: What is the Children's System of Care planning to do with this? This diagnosis of borderline personality cuts children from all services in the school districts, even though these are among the kids who need the most help. Children in the private system will have to fall through and end up in the public system before they get help.

Ms. Korfmacher: A lot of our children's programs are taking this training, so they will have the ability to provide the treatment. There are some private providers offering this DBT system. Also Langley Porter is in the process of developing DBT.

Ms. Brooke: Could you describe the difference between DBT and the standard treatment?

Ms. Korfmacher: A lot of people with this diagnosis are likely being treated by our intensive case management programs which provide an excellent service. The case managers can meet with people more often and can go out to where the client is and help them with emergency situations. That's our treatment as usual.

What's different about the DBT approach is that it's a combination of cognitive work and behavioral work. It's structured to deliver treatment specifically for individuals with this diagnosis. The skills training is something different. People are in classes with other folks with the same disorder and are learning specific ways to address the disorder.

Cutting actually works for people. It reduces their stress, and it's hard not to do that, given that it works. So you have to let people know that it works instead of saying "That's terrible. How could you do such a thing?"

Instead we say, "Yes, that works, but is there a better way to deal with stress, so you're not scarred, not ending up in the hospital, and not messing up your life?

For example, a client's father calls and says, "You're a screw up. Why aren't you out looking for a job? What are you still doing in bed at ten in the morning?" So the client is totally upset. Hopefully the client will call their therapist and say, "I'm feeling like doing some cutting." And the therapist can respond, "Let's think back about how else you can approach this behavior. The therapist can coach the person right then, using the strategies the person thought could work when they weren't under stress. The solution comes from the individual rather than the therapist.

We ask each client to keep a diary, and they record at least on a daily basis, their target behaviors, and when have they tried new behaviors. They bring those diaries in to the therapist.

Supervisor Dufty: If children aren't being eligible for services, oftentimes they can be diagnosed in other ways, so they will be covered. Do we educate clinicians in the different diagnoses to make sure children get the services they need? Should we talk to the City Attorney about eligibility strategies?

Dr. Cabaj: One of our goals is always to use accurate and correct diagnoses, but we often know that certain diagnoses can be used against someone. But often people are treated for other issues as well, like severe depression, for many people there are two diagnoses. We urge clinicians not to use a diagnosis that is pejorative unless it's absolutely the only one.

For children it's very difficult to diagnose this disorder. And it's often tied to behavior rather than a real mental illness. I think the clients who will benefit the most from DBT are adolescents and transitional youth.

Member of the public: How does case management tie in with this, and psychotherapy?

Ms. Korfmacher: Case management comes in the beginning. You won't launch into a big therapy program if the person has no housing. So we start there. But then with DBT instead of handling problems for the person, we coach the person so they can work out the problem and learn the skills themselves. And psychotherapy is very much a component of DBT. The client's therapist is part of the DBT team.

3.0 DIRECTOR'S REPORT

3.1 Report from the Director of Community Behavioral Health Services
Bob Cabaj, M.D.: I am pleased to be here again tonight. I'm very pleased that Bevan Dufty has joined us. He will bring leadership and vision to MHB. I've worked with him on a number of behavioral health projects, including the epidemic of syphilis, and the epidemic of methamphetamine usage city wide, but especially in the gay community.

With regard to the budget, the last few months it's been doom and gloom. But with the help of the Board of Supervisors, we have had much money restored. The final version of the budget will have to be passed by the full Board, and then goes back to the Mayor. A few days ago there was still a $5 million shortfall.

Public Health got $13.5 million added back, and CBHS got $6.2 million added back.

We're looking at not restoring money to just do what was done before. But to use money slightly differently to see if we can bring in new revenues and help make programs less vulnerable.

So we are very pleased, and we thank the Board of Supervisors. It's very clear that the Board understood the impact of the proposed cuts on the health system, and that we probably took a disproportionate hit in public health.

Dr. Cabaj distributed the director's written report:

Budget Update. The City has preliminarily adopted the FY03-04 budget. DPH received $13.5M in add back funding from the Board of Supervisors, restoring most service cuts. Citywide, the Board of Supervisors added back $5.0M more than available funding, so the City is trying to identify the balance needed. If this funding is not found, then some of the restored programs may be impacted. In Community Behavioral Health Services, the restoration of $ 6.2M was used primarily to restore contractual services.

Expanded Methadone Van Services. In June, 2003 the Methadone Van initiated services in a second neighborhood. Services started in March, 2003, in the Mission and have now begun in Bayview-Hunter's Point. This was made possible through a unique partnership with a Bayview church and a community outreach organization to provide facilities for secure van parking and counseling. The van provides methadone dosing and counseling services to clients who are enrolled at the SFGH OTOP. By bringing treatment closer to clients' homes, compliance, retention and treatment success are expected to improve. Methadone van services have been successful in Boston, Seattle, and Baltimore.

New School Readiness Mental Health Grant for Young Children. On June 2, 2003, the Child, Youth and Family System of Care of Community Behavioral Health Services was awarded a $200,000 grant from First Five San Francisco to implement a mental health school readiness Initiative at 10 selected San Francisco Unified School District 's classrooms citywide for this coming year. Services will include an array of coordinated classroom-based early childhood mental health services including assessment,

observation, consultation, direct therapeutic services, play groups and information and referral services. Activities will focus on child development, family involvement and enhancing the emotional well being of the young children for school readiness. The grant is scheduled for a three year funding cycle.

CBHS Response to Violence at the Dalt Hotel. On June 28, 2003, violence broke out at the Dalt Hotel located at 34 Turk Street, a Tenderloin Housing Development Corporation hotel. John Bravard, a tenant, was reported to have fatally shot three other tenants and critically wounded a fourth tenant who also worked as a night desk clerk. Mr. Bravard then killed himself. One of those who died worked at the Vincent Hotel (459 Turk Street), Department of Human Services master leased housing. .

Mobile Crisis staff provided five critical incident stress debriefings for staff and residents of the Dalt Hotel. Comprehensive Child Crisis Services also provided crisis counseling services at the Hotel.

Two debriefings were provided by OMI staff at the Vincent Hotel.

State Mental Health Initiative. The Campaign for Mental Health is a proposed ballot measure for the November 2004 election that seeks to ensure that everyone who suffers from a severe mental illness has a right to receive the necessary services. For adults that means integrated services as established under AB 34 (Steinberg 1999) and the Adult System of Care. For children it means the full range of services already guaranteed to MediCal recipients under EPSDT and Healthy Families. The measure would also include programs to prevent mental illnesses from becoming disabling, invest in human resources to meet the increased demand for services, and build housing and other necessary facilities. It is sponsored by the California Council of Community Mental Health Agencies and co-sponsored and supported by many other mental health organizations. The measure would be funded by imposing an additional income tax on everyone who makes more than $1 Million. Some advocates think that the current draft is too extensive and detailed and may lead to unnecessary additional bureaucracy, and a simpler version is being considered.

I was just at a meeting in Sacramento today about the initiative. A survey of the state showed that 78% of people would support state mandated mental health for adults and children. This would be mandated services along the lines of AB 2034. It would fill in the gaps and provide state funding for care for people who would not ordinarily get care.

The original proposition was 70+ pages, and has been edited down to 29, but I've been advocating that we just have a one-page proposition that essentially mandates the services and hands it over to a state department to manage and write the regulations.

If there is no real opposition to the initiative, we believe we can raise the money necessary to pass it.

Centralized Behavioral Health Court. In May 2003, SF Judge Susan Breall initiated a series of meetings with Community Behavioral Health Services (CBHS), Public Defender's Office, District Attorney, Probation, and other behavioral health service providers, to launch a Centralized Behavioral Health Court, which starts on July 14, 2003. This centralized court brings together the various drug and mental health courts, namely Drug Court (including Streets-to-Work for drug sales), Proposition 36 court (for first- and second-time, non-violent, simple drug possession offenders), and Mental Health Court.

The Centralized Behavioral Health Court will focus on addressing the treatment needs of clients. Together with service providers, CBHS, the Public Defender, District Attorney and Probation, the Court will use a combination of services, incentives, and sanctions, to get clients the help they need to not offend again, and to get their lives on an improved track. Services to be made available include mental health and substance abuse treatment, and case management to a variety of other resources such as housing, education, and vocational training.

The benefits of centralizing the courts include: more efficient use of the various departments' staffing, better coordination between the different court tracks, and improved clarity, consistency and effectiveness of practice with clients with experience built over time. The Centralized Behavioral Health Court will have the following weekly tracks: 4 sessions (days) per week of Drug Court; 2 sessions of Proposition 36 court (Mondays and Wednesdays); and one day of Mental Health Court (Fridays). There will also be a special Women's Drug Court, as well as a special Educational Court track under Streets-to-Work (for predominantly young people on minor drug sales charges).

Within its capacity, CBHS will provide the needed substance-abuse and mental-health treatment services for Behavioral Health Court clients. Given limited treatment resources, Court-mandated treatment service plans will be fashioned in close coordination with CBHS to ensure that the level of service resources identified in the treatment plan are available and appropriate to be allocated.

We're hoping to do the same with children's services in about a year.

Mr. Golub: I know with drug courts, recidivist activity puts a person in jail. But with mental health sometimes it takes longer than that to get things under control. Mental illness won't be cured within three months.

Dr. Cabaj: You're right, and it's too soon to know. Dr. Breall is looking at what she's going to do. We're hoping that the choice between outpatient treatment or going to jail will be a motivation.

Dr. Moses: The MHRF is one of this Board's pet projects and we want to keep it alive. The American Public Health Association (APHA) will be here in November with 18,000 people attending. What are you doing to welcome them?

Dr. Cabaj: Commissioner Roma Guy, Vice President of the Health Commission, is a very strong supporter of the APHA. Many of our staff will be going to their conference. We'll be setting up booths and tables. We've got a meeting coming up to plan our response to the conference.

One of the big concessions that helped meet the budget was that almost all the unions agreed to pay for their own retirement. And they did that with the agreement that the MHRF will continue. It doesn't have the same number of clients right now. We've been operating with 60 clients. And we have the staffing for that many. We've having a Blue Ribbon Panel review the MHRF. The Mayor asked for this and Mitch Katz is making the appointments. The first meeting is scheduled for September 3rd. We're excited about that. We can shape the program.

Ms. Shaffer: Regarding the grant for children in schools, how will we know about outcomes? What kind of accountability is there? How will the work continue after the grant?

Dr. Cabaj: We hope some of those moneys will be part of the state mandated funds. Every grant has outcome measures. Sai-Ling Chan-Sew, Director of Children's Services is an expert in this area of evaluations and does national consulting. We're hoping the outcomes will prove that there is a need for this program. We've got some time to work on this.

Supervisor Dufty: I've heard this issue in Committee at the Board of Supervisors. Sai-Ling presented it to us. I believe school nurses are an important part of reaching the children. Sai-Ling just told me about a symposium that Children's Services will hold on July 19th which will talk about this issue. School nurses are very, very important.

mr. martin: Has Behavioral Health Court developed performance criteria.

Dr. Cabaj: Yes, they are developing that now.

mr. martin: The mental health of this city is as big a priority as Fire Department or Police Department. I wonder if we might want to look at amending the City Charter to create a baseline budget for mental health? In the Health Department budget, mental health takes a disproportionate amount of hits when cuts are made.

Dr. Cabaj: In general, people try to avoid charter amendments, because they are so difficult, but often they are the only way to bring change. I'd have more discussion at the Board level about that.

Mr. Kalman: The MHRF has only 60 people, but the capacity is over a hundred. I believe the MHRF cannot benefit from any state funding for most of the customers in that facility. If we move those customers into small units, then can the state money come for the program?

Dr. Cabaj: The limit is 16 beds or less that the state will fund. Some of the contractors are re-shaping their programs to 16 beds. Many of the clients of the MHRF can move to those units. The biggest issue is whether we can change that exclusion. The MHRF is

considered an institution of mental disease. We're trying to get the federal government to change their minds on that, but don't think we will get very far.

Mr. Kalman: Treasure Island is a possibility for housing for the mentally ill. I would like the Health Department to follow up on that. I just got the use plan from the Navy. It's all hotels. But there is a federal mandate that any surplus federal property should go to the community.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: Our sixth Police Crisis Intervention Training will take place July 21-24. You are welcome to come to the graduation at 4 p.m. on the 24th.

We are now at 16 Board members. Six people have applied for the open Mental Health Professional Seat, and one person will be chosen by the Rules Committee on July 30th. That will bring us up to our full complement of 17 Board members.

Dr. Moses: Has the Mental Health Board budget been cut? Ms. Brooke: We took a very small cut. Rich will be doing a voluntary reduction of 7 hours a week.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee
Dr. Del Zotto: All August meetings of the Mental Health Board and its committees are canceled.

Dr. Janice Cohen is here tonight to present some recommendations for joint advocacy efforts. She is a psychiatrist, and is the Chair of the Mental Health Section of the American Public Health Association (APHA).

Dr. Cohen: I was on the Mental Health Board in 1995-96. At that time I was a physician but not a psychiatrist. I was a mental health researcher and studied the impact of system reorganization. I studied 4,000 clients using SFGH services before and after reorganization. I was also on the county Quality Management Committee.

But most importantly, I was a family member of a sister with chronic schizophrenia, and was her guardian. Just after I left the MHB, she was abandoned by her county mental health system back east and was placed in a geriatric facility, a facility with no psychiatric care. She subsequently decompensated, and was in and out of the hospital.

Medical care was withdrawn, and within six months she coded and died. I found myself in a situation where I had nothing I could do. A situation that is part of the discussion tonight.

How do we define and articulate what a community-based system of care means to our clients and reach some kind of consensus on what a model mental health system could be? I won't have enough time tonight to cover everything. I've tried to give a brief outline that frames the discussion about advocacy.

As Chair of the Mental Health Section of the APHA, and as a former psychiatrist at the Mental Health Rehabilitation Facility for over a year, I have a pretty good overview of the system, as well as the perspective of family members and clients.

I won't be able to cover everything on my agenda, but I want to raise some of the issues. I want to help identify some of the advocacy issues, and look at barriers and opportunities for joint advocacy.

Also I want to look at research on evidence-based treatment. There is a national movement that will help us with this.

The most important thing is the immediate issue. There is a state mandate for Mental Health Board duties, a specific set of responsibilities that can be interpreted many ways. For anyone who has not read them, I recommend you put that on your agenda to understand where your mandate has come from and how you want to interpret the mandates for yourselves.

It's important in deciding how you want to assume your advocacy rules, to look how these mandates are aligned with the Department of Public Health and understand how they translate into action and policies.

I want to recommend that we do a better job of working together across all the advocacy groups and constituencies, and to decide what the priorities are and what we are going to do to accomplish those.

For example, a coalition developed around the MHRF, including family members and clients, the union, and members of Save Public Health.

I put on my list a broad range of organizations and boards, community-based organizations, small and large businesses, political groups, and special interest groups. Part of the process of advocacy is to understand working together as a coalition, the roles they play and what their priorities are.

We need to look at alignment with state and national issues. The issues coming up here in San Francisco are relevant to trends, battles, federal initiatives, lawsuits, and legal mandates across the country. The trend is for mental health systems to be dismantled. Mental health is often a special system, called a carve out, meaning separated out from other issues.

Mental health and substance abuse are still separately funded and managed on the national level. Even though there is a lot of talk about integration of mental health and substance abuse, we are still far away from any federal initiative which would allow states and counties the flexibility in funding streams to do integration properly. It's important for this group to be aware of what the state of the art is on integration and to have access to what models are being proposed.

One of the main reasons mental health has been a carve out for so long, is because it's always been the one that is sacrificed when it is in a pool with other primary care services.

On the national level, strong consumer advocates are requiring from all the state and regional mental health departments that the entire focus and approach of services be recovery oriented. And recovery has its own set of policies and accountabilities to make that a reality within systems of care.

With regard to the client -and performance-driven system of management, for the last ten years, anyone responsible for providing services, has been supposed to show that their services in fact help people. That describes what we call outcome-driven systems of care. There have been numerous initiatives to make this happen. California and San Francisco, have done a really poor job of using outcomes to drive the design and maintenance of programs.

With regard to cost effectiveness, evaluation, and implementation, I proposed years ago a methodology for doing state-of-the-art assessments of needs, to use the state-of-the-art technology, to put together information from multiple stakeholders. The idea was to come up with a good view of who our clients are, what they should have, and what outcomes we expect them to have.

Dr. Moses: Since you are the Chair of the Mental Health Section of the APHA, how do you think our board could be recognized and/or get involved?

Dr. Cohen: Mickey Shipley is our liaison. I'm hoping we can set up a special program for mental health advocates. Maybe a forum or event.

6.0 NEW BUSINESS

Mr. Douglas: Could we think about changing our meeting date, because Dr. Cabaj is in Sacramento on the second Wednesday.

Dr. Moses: I'd recommend thinking about inviting Dr. Weinstein, who advocates for mentally-ill people in the jails, for a Board presentation.

Ms. Brown: I'd like to invite everyone to come to the Program and Services and Children's Committee meetings.

7.0 PUBLIC COMMENT

Mr. Kalman: I would like the Mental Health Board to take off the back burner, Resolutions MHB-96-32, and MHB-96-27. There is a federal mandate that surplus property like Treasure Island be used for community needs such as housing for mentally-ill people. There is a deadline of July 28.

There being no further business, the meeting was adjourned at 8:27 p.m.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103-2614
(415) 255-3474 fax: 255-3760
TTD: 255-3449
mhb@igc.org
www.sfgov.org/mental_health

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cancelled

Agenda

The Mental Health Board meeting scheduled for August 13, 2003, has been CANCELED

The next meeting of the Board will be Wednesday, September 10, 2003, in Room 537 at 1380 Howard Street.

An agenda for that meeting will be sent out at the beginning of September.

DOCUMENTS DEPT.

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, September 10, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of July 9, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 10, 2003, to the following members: Idell Wilson

2.0 PRESENTATION: BEHAVORIAL HEALTH COURT UPDATE (50 minutes)

Judge Susan Breall will present the status of Behavorial Health Court

30 DIRECTORS REPORTS (30 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (25 minutes)
For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee.
Discussion of budget policy and strategy.

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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Telephone: (415)554-7724
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Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
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UNADOPTED MINUTES
Mental Health Board
Wednesday, September 10, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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OCT - 6 2003

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BOARD MEMBERS PRESENT: Ted Stinson; (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas; Supervisor Bevan Dufty; Carol Knight; Toye Moses, Ph.D., M.P.H.; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Kate Walker; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Idell Wilson.

BOARD MEMBERS ABSENT: chance martin; Dennis Yun, M.S.W.

PRESENTER: Judge Susan Breall, Superior Court

OTHERS PRESENT: Linda Wang (Community Behavioral Health Services); Allison Soltau (SF Examiner); Jennifer Alvidrez, Ph.D. (University of California San Francisco); Richard Gee (Drug Abuse Advisory Board); Mark Miller (Executive Officer, Citywide Alcoholism Advisory Committee, and Drug Abuse Advisory Committee); Emeric Kalman; Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was called to order at 6:39 p.m. by Ted Stinson, Chair.

Mr. Stinson: Tonight we have a new member of our Board. Her name is Rebecca Turner and she was appointed by the Board of Supervisors to a Mental Health Professional Seat. She received her Ph.D. in Psychology from George Washington University in Washington, D.C. and is currently serving on the faculty of the California School for Professional Psychology which is part of Alliant International University.

Dr. Turner: I'm very pleased to be here. I have a number of different interests including the effectiveness and evaluation of treatment programs. I was in adolescent medicine at the UCSF Medical Center before becoming a professor at the California School for Professional Psychology. I'm looking forward to getting to know you.

Mr. Stinson: Our Board member Jay Golub decided to move back to New York City.

Supervisor Tony Hall will join us at our meeting on October 8, to officially swear us in as Board members. On the one hand swearing in is just a formality. On the other hand it recognizes the importance of what we are doing.

Mr. Stinson then asked Mr. Gee from the Drug Abuse Advisory Board and Mr. Miller, Executive Officer of the Drug Abuse Advisory Board and the Citywide Alcoholism Advisory Board to introduce themselves.

The Treatment on Demand Retreat was announced. It is to take place on Saturday September 13, at the Holiday Inn at 50 8th Street from 9-5. The purpose is for DPH advisory boards to discuss the integration of their work as part of the integration of Community Behavioral Health Services. All MHB members are very much encouraged to attend.

Additionally, MHB members are encouraged to attend the Treatment on Demand Council's meeting Thursday evening September 11 from 5:30 to 7:30 in the 4th Floor Conference Room in preparation for the Retreat.

1.2.a RESOLUTION (MHB-2003-19): Be it resolved that the minutes of the Mental Health Board meeting of July 9, 2003, be approved as submitted. (Passed unanimously.)

1.2.b RESOLUTION (MHB-2003-20): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of September 10, 2003, to the following members: Idell Wilson. (Passed unanimously.)

2.0 PRESENTATION: UPDATE ON BEHAVIORAL HEALTH COURT (BHC)
Mr. Stinson introduced Judge Breall as follows: Susan Breall is a Judge in the Superior Court for the City and County of San Francisco. Prior to her recent appointment to the bench, she was Chief of the Criminal Division of the San Francisco District Attorney's Office for all crimes of violence against women, children, the elderly and intimate partners. She was an assistant District Attorney for over seventeen years. Her caseload included homicides as well as cases involving false imprisonment, aggravated assault, stalking, torture, mayhem, sexual assault, simple assault and battery in a domestic violence context. Currently, Judge Breall is in charge of the Treatment Court in San Francisco. Treatment courts consists of the behavioral health court, drug court, drug cases handled pursuant to Proposition 36, and the Streets to Work and Streets to School collaborative court programs.

Judge Harold Kahn presented to our Board on January 8, literally the first day of operation for the Behavioral Health Court.

Judge Breall: Thank you very much. Treatment Court was started on July 14th of this year. Treatment Court includes several tracks. Also I'm doing the Y-TEC (Youth Treatment and Education Court) court out of YGC. Treatment Court is an alternative to the regular courts. It's a therapeutic court. The aim is to get the defendants out of the criminal justice system and into treatment.

One of the tracks of Treatment Court is Behavioral Health Court. Judge Donaldson is currently doing the BHC track. There are approximately 60 defendants with serious Axis One disorders, such as schizophrenia, bipolar, or major depression. These defendants have been charged with rather serious felonies, such as felony assault, possession of a gun, or arson. Most of the charges are serious.

I think it's a rather amazing court. We use a team approach with representatives from the District Attorney's Office, the Public Defender's Office, Jail Psychiatric Services, and we work with amazing therapists. We spend 2.5 hours at our pre-court team meeting discussing and agonizing over every single case to figure out what would be the best thing to do for each person.

At first, as a Judge, I was pretty ignorant about all the programs out there . But I got to learn about them, and learn about the disorders. Right now this is a pilot program. I think we need more treatment court capacity in every individual one of our courts. So that is one track.

Every day I do the Drug Court from 2-4:30 p.m.. We have 380 defendants in drug court. Those cases are difficult to handle. Telling a defendant not to take the wrong kind of drugs, but to take the right kind of drugs is challenging. Trying to get them into live-in drug treatment programs that can also address their mental health issues is a challenge. Often we have triply-diagnosed individuals, who are dealing with HIV, mental illness, and substance abuse.

I think this is an amazing court. I would encourage anyone interested to come sit in and see what happens.

We get to establish a real rapport with the clients as opposed to regular court where you talk through the lawyer. This is not the adversarial system.

For example, one individual, was diagnosed with severe depression. The first week I saw him, I said, "How are you doing?" "I've been worse." I said, "Well, that's better than worse. It's a pleasure to meet you."

The next week he said he was doing okay.

The week after that he said he was doing "pretty good." We track the defendant's progress. We work on getting him into a program, and talking to him about his issues. A defendant might show you a picture he's drawn and it turns out he's an amazing artist. Defendants might give you pictures of their dog and write you letters, and week after week you get to see progress.

There is an amazing amount we Judges don't know. What I've established and am starting tomorrow is training for the Drug Court team and Behavioral Court team. We want to know what the milestones are that we should be looking for to measure progress with different individuals.

We have two psychiatrists form UCSF who have volunteered to come train us. Tomorrow the topic is legal drugs for addicts.

Next Thursday, the topic will be risk assessments, specifically can you rely on them. We have clients who make threats. That's a felony. The question is how do you assess those people. How is a risk assessment done? And how good are they?

We're having a training on marijuana, the physical and psychological effects.

With one young woman I was working with, it was a milestone for me to get her to go to the Iris Center and participate in groups. For her just, keeping out of the system and not picking up a new offense was a victory.

In Drug Court we use sanctions and incentives. The ultimate incentive is graduation, when the client gets their felony dismissed and probation is terminated.

What is an appropriate sanction with a mentally ill client? Jail is not always appropriate and people get immune to jail. For example, the prostitutes I've worked with get very used to jail.

Also with the young people jail is not an appropriate sanction. For one young man it was much more important to say he couldn't go off the school campus for lunch with his friends. He cared more about that than about going to jail, so he obeyed his curfew.

In the criminal justice system we are talking mostly about poor folks, who are not highly educated and have low self-esteem. They understand when they have messed up.

I tell them that I know how bad they are feeling and that I know they are going to pick themselves up and start over again. I tell them that I wouldn't have them in my court if I didn't think they could do this.

We're talking about people who have been through a lot and are suffering from PTSD. Whether or not they have mental health issues, they have stress that most of us can't begin to know about.

BHC is really just one track of a larger treatment court. We use the therapeutic court model. It's exciting, but there is a lot more work we need to do.

I've started a separate track of all women in Drug Court on Thursday afternoons. Drug Court and BHC are tough courts. I ask a lot of questions. The clients have to stand up in front of people and answer them.

A lot of women have used drugs to self-medicate because of child abuse, rape, and other kinds of assault. Perhaps 85% of drug-addicted women have been abused.

On September 29th, Rhodessa Jones, founder of the Medea Project, will be at our graduation, and you're invited.

Dr. Moses: I'm just happy to finally meet you. I work for Jail Psychiatric Services on call. It's nice to see someone who really cares. I agree with you and appreciate your

compassion for the people in your court. What do you think about some patients who are sent out but come back in soon, the revolving door syndrome.

Judge Breall: I haven't experienced the revolving door with BHC because it's too new.

In Drug Court, you see relapses. Statistics indicate that these clients are going to relapse 12-13 times before they are off drugs for good. We struggle to find creative sanctions other than jail. One young man was not following through. Finally I said, "You have to come to court every single day, and hear everyone else, and tell me what you learned at the end of the day. And you have to write a report." It turned out that he's a great writer. He got up and read a beautifully articulate report. Everyone cheered. So for the first time, he had something to be proud of. He really looked forward to doing the reports each day.

The system is not perfect. Often there is a revolving door. But the therapeutic court model is that we struggle to find alternatives.

One person we had in court wanted to be in jail until we found him a program so he wouldn't relapse.

Ms. Walker: You spoke of having 60 defendants. What is the structure of the court. How is it that you see people over and over again?

Judge Breall: First we have a team meeting, Wednesday from 2-5 p.m., where we create plans for each case. Then we have court the next day. We talk with each defendant about the plan for him or her. We want to track them, so they come to the court each week. Approximately 80-90% are out of custody. The object is to get them out of jail, and then to get them out of the criminal justice system. Why would you want to warehouse them in jail or state prison, when what they need is wraparound services out in the community?

More defendants are in custody in the Drug Court track than in the Behavioral Court track.

Mr. Luebkeman: What is the relationship between BHC and AB 1421, Helen Thomson's bill, which provides the ability to force people into treatment before they've committed a crime. Do you see any potential value in that?

Judge Breall: I don't know very much about AB 1421, and I take my cue from the people on my team who are the experts. What they've taught me is that you can't force people into treatment if they don't want treatment.

When I start working with someone. I tell them how excited I am to see them, and how impressed I am with their courage to be in this court. This is not an easy court.

I tell them my key rule: Everyone treats everyone else with respect. There is no laughing and no talking when someone is talking. It's hard to get up and talk in front of court.

My other rule is that everyone needs to be honest. I'm going to expect people to do what their treatment providers ask them to do. So if providers are asking them to stay on their medication or to stay with programs, I expect them to do that.

I'm a novice. I'm not a doctor or a therapist. I've been doing lots of reading and studying. But I don't know that forced treatment works.

Do you have an opinion?

Mr. Luebkeman: My concern is that sometimes people on the street are so ill that they don't know they're ill. But I'm not an expert. The biggest concern is when someone is potentially a danger to others, but hasn't committed a crime yet, then how do you intervene?

Dr. Moses: My experience with people with substance abuse is that the people who were referred by the court stayed and completed the program.

Dr. Breall: Drug court is a voluntary court, but once you're in it, it is a coercive court. It's a coercive model. The theory being that eventually something will click while you are in treatment.

Mr. Stinson: We as a Board have been considering AB 1421 for a couple years, and when we voted on it about nine months ago, we were split right down the middle on it. I'm interested in the interplay between sanctions and treatment, particularly the medication aspect. If someone is ordered to take medication and they refuse do you look at sanctions to compel them to take medications?

Judge Breall: I was talking to a woman in the court and asked her if she was taking medication. She said, "No, it makes me sick." Her therapist was in shock upon hearing this. It's interesting that some things come out in court that they haven't told their own therapist.

Here's someone who was honest and I told her I appreciated her honesty. And I asked her to promise to take medication as her therapist directed.

Ms. Walker: Thank you, Ted, for that question. What if someone said, "Let me show you I can do okay without medication"? Some people like me are deathly afraid of being on psychoactive medications. Would you give her that chance?

Judge Breall: I would have to look at her whole history. If she's in my court she's committed a serious, and often violent, offense, so there is a public protection aspect. I'd have to look at all the details of her past. I might let her have a chance off her medication, but it depends on what the crime was.

Ms. Walker: You make me feel much better when you say you would look at it on a case by case basis.

Ms. Shaffer: I'm interested in how schools handle something like the case of not letting the child go off campus at lunch time.

Judge Breall: That was a case in Youth Treatment and Education Court. It's a small school. All the kids there have a minimum prior record. The DA's office screens those kids carefully. It's a school attached to the court, and it's an accelerated learning program so they can get up to speed with their peers. It's an excellent school. We're talking about kids who are very capable. A lot of them are extremely intelligent. But a lot of them have parents who were drug abusers, or neglected them, etc.

This is a very contained and very structured school. The school is so successful that other schools have been wanting to send kids to it.

Mr. Miller: Thanks very much for your work. It's nice to know that there are people like you out there. Is this court something that is being done in other cities?

Judge Breall: There are other BHCs and they may have different names, but they are cropping up all over. But we are in a time of budget crisis, and many people are donating their time to this.

We were lucky enough this summer to get a law student from Golden Gate University, with a masters degree in forensic psychology. She had worked in the Behavioral Health Court in the Bronx. She had great suggestions on our team. But she was donating her services for free.

Ms. Soltau: Is there a graduation for BHC and an ending of treatment?

Judge Breall: Right now BHC is so new. If someone has a felony offense, this is a pre-pleas court. In other courts around the country, people come into the court after a plea. It may be agreed that after a year, the charges can be reduced.

We haven't had a formal graduation yet in Behavioral Health Court, because this court is still so new. In Drug Court, we have formal graduations.

Ms. Soltau: Have you had people with whom you've exhausted alternatives and sent them back to incarceration.

Judge Breall: We've had that in drug court, when programs won't take a client back, and so they go back to jail. But we don't give up on them. We don't ever give up. I haven't seen anyone just throw up their hands and give up.

Ms. Soltau: How have the City budget cuts to the Department of Public Health affected the programs you want to get people into?

Judge Breall: Certainly bed space is more limited. But DPH is still committed to providing services and we're still getting people into programs. I don't know how it's being done. We could certainly use a lot more funding. We're doing this program at the least optimal time to being doing it, but maybe this is the most important time to be doing this.

We see a lot of people in drug court who are self-medicating who should probably be on some other medication instead.

Mr. Stinson: This has been very informative. Thank you. We're glad to see that it's being very successful. We'd like to invite you back for further updates. There is a particular interest around AB 1421. The MHB has wrestled with this. This is potentially something we will be struggling with in the future.

Welcome to Supervisor Dufty. Thank you for coming and joining us this evening.

3.0 DIRECTOR'S REPORT

3.1 Report from the Director of Community Behavioral Health Services

Linda Wang reported for Robert Cabaj, M.D.:

Mental Health lost a couple hundred thousand dollars from the state budget this year and it came out of our managed care budget. We are trying to figure out how to deal with that loss.

We lost residential treatment beds. Westside Lodge had to reduce beds. Also Conard House. Westside Lodge is splitting their program and moving into two separate facilities so they can be at 16 beds or under so Medi-Cal will reimburse them.

We lost some fee-for-service inpatient dollars.

The Mental Health Rehabilitation Facility was restored in terms of the budget, in large part because the unions voted to contribute to their own retirement, which meant a 7.5% pay reduction.

Supervisor Dufty: Supervisor Ammiano asked for a hearing on the status of the MHRF. It will come before the committee I chair. A task force was created on the MHRF but I don't know if the task force has met yet.

Mr. Luebkeman: All these issues about the MHRF, will they come up next year?

Ms. Wang: It's quite possible, because the problem is that they can't bill Medi-Cal . Last I heard a couple weeks ago, there are only 60-70 patients at the MHRF. Admission is re-opened now.

Dr. Moses: It's great that the Supervisors have taken such an interest in the MHRF.

The written Directors Report was distributed:

1. Budget Update. On August 2, 2003, Governor Davis signed California's $100 billion budget for 2003-04 with general fund spending budgeted at $7 billion less than 2002-03. This is the fourth time in 50 years that General Fund spending has been reduced compared to the previous year. The net effect to our County Mental Health System is $200,000 or approximately 5 percent reduction to our managed care program. There no new information regarding the City budget since the July, 2003 report.

2. Medication Adherence Project. In cooperation with Westside Community Mental Health and support from an unrestricted grant from Eli Lilly, the Quality Management Unit of Community Behavioral Health Services completed an eighteen-month pilot designed to improve medication compliance. Up to 26 inconsistently medication compliant clients were enrolled in this project. The results appeared to be very promising. Over 80% of the enrollees were tracked on a daily basis. Of this number, there was an average of 98% compliance, various acute service costs were reduced by 42 to 95% and providers noted that many of the clients made significant gains in quality of life issues during the pilot period. Even when compared with a similar cohort of clients, acute service use reduction was favorable.

3. The San Francisco Single Point of Responsibility (SPR) Programs: Five Year Cost Analysis. The Quality Management Unit of CBHS, with assistance from an evaluation contract with Davis Y. Ja and Associates, has completed a five-year analysis of the county's three SPR programs has been completed. Single Point of Responsibility (SPR) programs provide capitation-funded assertive community treatment services and began in San Francisco early in 1997. This analysis compared the cumulative costs and the number of days in locked care of 248 clients enrolled in an SPR program to the cumulative costs and locked days of 300 comparison clients who were eligible for the SPR programs but did not enroll.

Overall, results suggest the SPR programs are cost saving for the county after five years. The effects of the SPR programs, however, appear to be different depending clients' service costs and locked care service use during the year prior to enrollment (baseline year). Clients with high service costs who used locked care services during their baseline year showed the most dramatic cost-savings and spent less days in locked facilities. Clients with low service costs who used locked care services during the baseline year as were cost neutral at the end of five years, but had used less locked days. Clients who used no locked care services during baseline were also cost neutral at the end of five years and used about the same number of locked days; the initial investment in SPR clients is paid off after five years. Clients cost no more than they would have had they not been enrolled in an SPR and, among high service users, cost less. More importantly, the high service cost clients had an improvement in quality of life incident to spending less time in locked facilities.

Mobile Crisis Treatment Team (MCTT). In FY 02-03, MCTT received 2,670 requests for services, conducted 886 field visits, and saw 691 unduplicated clients. The Team provided assessments and linkage to follow-up care. The 886 visits included 742 initial field visits, 91 follow-up field visits, 37 medication linkage visits and 16 follow-up medication linkage visits. The 5150 rate for all clients seen was 43%. As part of MCTT's mission to reduce use of acute care, 131 evaluations were also performed by MCTT in fee-for-service hospitals. The 5150 rate for MCTT evaluations at St. Luke's Hospital emergency room was 55% and at St. Mary's 60%. To reduce use of inpatient facilities when possible, a variety of strategies/facilities were used, e.g. crisis residential programs (34 successful admissions).

Other important activities during the year included participation in the Police Crisis Intervention trainings, 5150 training for staff, consultation services, intern training, and stress management debriefings following critical incidents.

AB 2034 Homeless Outreach Program. The annual outcome report for FY 02-03 showed a reduction of 40% in annual average number of psychiatric hospitalization days, a 75% reduction in annual average number of days incarcerated, an 84% reduction in annual average number of days homeless on the streets or in shelters, and a 49 % increase in annual average number of days employed. The program has served 205 clients since its inception; in FY 02-03, 163 clients were served.

Critical Incident Response Team (CIRT). CIRT provides individuals and families in the Southeast sector of the City who are the victims of violence with case management and counseling services and provides groups and organizations with defusing and debriefing services. Collaboration with community organizations and agencies is an important activity supporting the Team's effectiveness. During the fourth quarter, 48 individuals were contacted of which 15 received assessments, 10 were case managed (e.g. relocation assistance, assistance with funeral arrangements, help with entitlements, etc.) and 5 received brief counseling. Two critical incident stress debriefings were provided.

Mr. Douglas: How are clients referred to the MOST team?

Ms. Wang: We have a certain percentage referred from jails, a percentage of Transitional Youth from 18-24 , individuals not linked to mental health services who showed up at SFGH, and community referrals from places like veteran's programs. These are all people who are homeless and not linked to a mental health program already. We did a lot of publicity when it started. There is not a lot of turnover now, so we're only taking limited referrals.

BD: Who is the contact person for the MOST team? Ms. Wang: Jacqueline Moskus.

Mr. Stinson: Two years ago on the day of our MHB Reception, we took Dr. Stephen Mayberg, the Director of the State Department of Mental Health, on a tour of the MOST program. He went along as the MOST team did outreach to people living under a freeway, as they dropped a clean pair of socks, an apple, and a candy bar to a man they are working on connecting with. They visited a woman who was in a residential facility. She had been on the street for seven years. It took 7-8 months of low-key outreach to get her to accept services. The work of the MOST Team is pretty impressive.

I just did the math and it comes out to $10,000 per person for the MOST Team. That sounds like a lot until we think that it costs $500 for police visit, or $1,000 for psych emergency. It doesn't take long of getting a person off the street to make the $10,000 worth it.

Ms. Wang: It does take that kind of intensive outreach. Many people are distrustful of the system. We've done a good job of people getting into housing.

Dr. Moses: How do you coordinate outreach to avoid duplication? Ms. Wang: There is a coordinating committee that meets monthly.

Ms. Shaffer: What about making Mobile Crisis 24 hours? Ms. Yuen: When we met with Supervisor Aaron Peskin he said we would need to do a study to show how it would save money.

Ms. Shaffer: It looks like Mobile Crisis needs to be pursuing data collection to write a report for the Board of Supervisors.

Mr. Stinson: The MHB can ask how we can take this data and help make it tell the story. We can use our skills on this.

Mr. Douglas: I think we need to get data from counties that have these 24-hour operations to show that there would be a savings within two to three years.

Ms. Brooke: As part of the Police Crisis Intervention Training, we have an evaluation component. Bill McConnell of Quality Management has been working with the Police Department to collect data on their calls, and the 5150s to see what the resolution is and when the calls come in. We are hearing anecdotally from the Police Department that they really want a 24-hour Mobile Crisis. If the situation does not involve a crime or dangerous situation they want the Mobile Crisis team to come out .

Once it gets up and running it can be self-supporting. The money saved is across departments. San Jose has had 24-hour Mobile Crisis, and have just cut it back. The Police Department there is really upset.

Sgt. Michael Sullivan and I were on the Gene Burns show on KGO, and Mr. Burns has offered to publicize Mobile Crisis.

Joel met with Supervisor Fiona Ma and she is offering to do a hearing in mid-October on 24 hour services.

Supervisor Dufty: My response is that right now is the perfect time to seek the help of the Mayor's Budget office because this is not the budget season. Send me a short e-mail about what would be helpful to look at, and I could ask Ben Rosenfield to see if someone can be assigned to work on that.

Mr. Kalman: I was at the Board of Supervisors yesterday. I would like either the Controller or budget analysis to send a draft to the MHB so we can discuss the situation. As far as I know a part of the MHRF is under the operation of another entity, not the City.

Ms. Wang: The adult services are operated by the City. There is a part of the building that is used by a contractor for treating adolescents. It's the Seneca program which has been in operation since the building was opened.

3.2 Report from the Executive Director of the Mental Health Board

Ms. Brooke introduced Jennifer Alvidrez: I'm from UCSF and am doing research on looking at stigma in the African American community. I'm developing a consumer-based psychoeducational plan for people to use prior to going to their first appointment. I want to talk with African American consumers, advocates, and providers. I'll be developing an intervention on stigma and testing it to see if it has impact on people's decision to sign up for treatment.

Dr. Moses: What kind of criteria are you going to use?

Dr. Alvidrez: I'll be using an open-ended interview. I'll be asking people what kind of language to use. I don't hear them using the word stigma. Then when the intervention is developed, it will be done with clients who are referred to therapy by the ACCESS Team.

Dr. Del Zotto: Are you part of a larger research team?

Dr. Alvidrez: I'm part of a reassert group at the UCSF Dept. of Psychiatry. African Americans tend not to use outpatient treatment as often as other groups. This project is to encourage them to make use of treatment.

Ms. Shaffer: Are you also going to be interviewing the families who are part of the support system and who are dealing with stigma?

Dr. Alvidrez: Right now the funding is very limited, so we'll be starting with consumers, and then we hope to broaden it to families.

Dr. Moses: I met with Supervisor Tom Ammiano, who is supposed to come to our meeting some time. I would like to request a budget update about how the Mental Health Board is doing budget wise.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee

Mr. Stinson: I'd like to remind everyone about the Program and Services and Children's Committee which meets on the 4th Wednesday of the month.

Our Annual Retreat will be on December 6 th. Please start now thinking about what's important for you for next year, to help us shape the Retreat.

6.0 NEW BUSINESS

Items to follow up on included: MHB budget, AB 1421, and 24-hour services.

7.0 PUBLIC COMMENT

A member of the public made a request for information.

There being no further business, the meeting was adjourned at 8:32 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, October 8, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

Supervisor Tony Hall will be present at some point during the meeting to do an official swearing in ceremony for Mental Health Board members.

1.1 Call to Order and Announcements from the Chair

The Sunshine Ordinance prohibits the use of electronic sound-producing devices at/during public meetings. Please be advised that the meeting chair may remove any person(s) responsible for the ringing or use of cell phones, pagers and similar sound-producing electronic devisces fro the meeting room.

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of September 10, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 8, 2003, to the following members: none

2.0 PRESENTATION: MENTAL HEALTH ISSUES AT YOUTH GUIDANCE CENTER (45 minutes)
For discussion.

Gwendolyn B. Tucker, Chief Probation Officer of the Youth Guidance Center, will present to the Board about mental health issues at the center.

3.0 PROPOSED CHARTER AMENDENT REGARDING THE DEPARTMENT OF PUBLIC HEALTH (15 minutes)
For discussion.

Supervisor Chris Daly will make a short presentation on his proposed Charter Amendment to protect the funding for Public Health and to change the structure of the Health Commission.

4.0 DIRECTORS REPORTS (25 minutes)
For discussion.

4.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

Presentation on the budget of the Mental Health Board.

4.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

5.0 MENTAL HEALTH BOARD COMMITTEES (20 minutes)
For discussion and proposed action

5.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

5.2 PROPOSED ACTION: Be it resolved that the Mental Health Board takes a position of support for the Behavioral Health Court. (Attachment A)

6.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

7.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

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Donna Hall
Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: Donna_Hall@ci.sf.ca.us

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MENTAL HEALTH BOARD
ATTACHMENT
October 8, 2003

PROPOSED RESOLUTION (MHB-2003-xx):
IN SUPPORT OF THE BEHAVIORAL HEALTH COURT

WHEREAS, far too many people with mental illness end up in the criminal justice system rather than in the mental health system, and

WHEREAS, these people with mental illness need treatment rather than punishment, and

WHEREAS, the newly-developed Behavioral Health Court is proving itself to be a very effective and humane way to help mentally ill offenders get into treatment, and

WHEREAS, the Behavioral Health Court involves a multidisciplinary team and is an excellent role model for the coordination and integration of services across City departments, and

WHEREAS, the Behavioral Health Court helps keep clients from falling into the cycle of recidivism, and

WHEREAS, the Mental Health Board has had two presentations on the Court, one by Judge Harold Kahn on January 8, 2003, the first day of operation for the Court and one on September 10, 2003, a nine-month follow up by Judge Susan Breall, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board commends the City and County of San Francisco for creating and supporting the Behavioral Health Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Superior Court of the City and County of San Francisco, and especially Judges Kahn, Breall, and their colleagues for their strong commitment to the Court and their compassion for the clients of the Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to make it a priority to increase funding and support for the Court, so the Court can increase the number of clients it works with..

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

UNADOPTED MINUTES
Mental Health Board
Wednesday, October 8, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

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BOARD MEMBERS PRESENT: Ted Stinson; (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas; Carol Knight; chance martin; Toye Moses, Ph.D., M.P.H.; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; Dorothy Shaffer, R.N., N.P., M.S.N.; Kate Walker; Sandy Yuen.

BOARD MEMBERS ON LEAVE: Supervisor Bevan Dufty; Rebecca Turner, Ph.D.; Idell Wilson; Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: none.

PRESENTERS: Supervisor Tony Hall and Supervisor Chris Daly
Gwendolyn Tucker, Chief Probation Officer, Juvenile Probation Department

OTHERS PRESENT: Bill McConnell (Community Behavioral Health Services); Jimmy Jones, M.D. (Medical Director, Community Behavioral Health Services), Emeric Kalman; LaVaughn King, Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR

The meeting was called to order at 6:35 p.m. by Ted Stinson, Chair.

3.0 PROPOSED CHARTER AMENDMENT REGARDING THE DEPARTMENT OF PUBLIC HEALTH *(This item was taken early in the agenda.)*

Supervisor Daly: This proposed charter amendment which I introduced several weeks ago will be heard in Supervisor Hall's Committee on the 22nd of the month. Basically this charter amendment comes out of my experience as Chair of the Budget Committee this past year. It was an uncommonly difficult year. We started with a $350 million deficit. What we saw were some very difficult health cuts. There were difficult proposals to raise fees. But some of the cuts in the Department of Public Health were the most staggering cuts.

Interestingly enough, in the San Francisco Charter there are set asides to protect different parts of the City's operations. The Library has a set a aside. The Library

Commission sends a budget to the Mayor and the Board of Supervisors, and we basically adopt it. The Opera has a set aside. There is a children's baseline. There is an open space fund.

What my proposed charter amendment will do is set a baseline for funding for the Health Department. Last year the amount from the General Fund was $300 million. It will allow the Controller to look at revenues and the amount available in the General Fund and if those revenues have gone up, then a certain percentage gets allocated to public health.

This would take a lot of the guess work out of providing health services. We had probably 300 people come to the Board of Supervisors meetings this year. Testimony was provided on mental health, substance abuse, HIV, and homeless programs in the Department. People didn't know on July 1st if their program would still be in effect. This charter amendment would take that guess work out of the budget.

The charter amendment does several other things. It puts Laguna Honda and San Francisco General Hospital into the charter, which is important to do in this era of budget cuts. I recently took a trip to Washington, D.C. I found out that the DC General Hospital has closed. I was just speechless.

We need to protect our community clinics. This proposal sets DPH as the lead agency in trauma care. It creates a division of housing and urban health. It locates responsibility for homeless programs in DPH. It has a timeline for healthcare for all, universal health care, by 2008. It also streamlines the contract process. It also sets specific goals on certain modalities of substance abuse treatment to decrease waiting list to under 30 days by 2005.

The Mental Health Rehabilitation Facility was a big flash point of debate during the budget hearings. I've crafted some language that both the Department and the families and advocates of the MHRF can agree on, namely that the City shall operate the MHRF, and that substantive changes can only be made with the approval of the Director of the Health Department, the Health Commission, and the Board of Supervisors.

Mental health services are included in this proposal to ensure that the City will continue to provide those services for our community. This is a very big charter amendment in terms of being a $300 million item every year. I'm looking forward to discussing it at the Rules Committee.

Dr. Moses: I'm looking at the section on the Health Commission. Is it correct that the Commissioners would be appointed by the Mayor, and after a hearing, confirmed by the Board of Supervisors?

Supervisor Daly: I actually respect the work of the sitting Health Commission greatly. I left the appointing authority with the Mayor, but included a mandatory hearing at the Board of Supervisors. Currently the Mayor appoints commissioners to fixed terms. This will make sure that the commissioners comes through the Rules Committee or other appropriate committee.

Dr. Moses: You don't think that will slow down the process? Supervisor Daly: It doesn't slow down the process, but opens it up for the public to come and testify. Out of all the commissions in the city in the last ten years, the Health Commission has had one of the higher levels of commissioners in my opinion.

Dr. Moses: What about Jail Psychiatric Services? Where would that fit in, in the forensic part? Supervisor Daly: In terms of this charter amendment, it wouldn't affect programs in the county jail, but any program funded by DPH would be protected.

Dr. Moses: It might be good to include the Jail Psych programs in this charter amendment.

Mr. Stinson: The residential mental health treatment beds 30-day timeline has been struck out. Supervisor Daly: I wanted to decrease the waiting time for residential beds, but Dr. Katz who I've been working with closely, said he didn't think it would be possible without an additional commitment of resources. If there is a push from the community, this is language that could reappear. They felt because of the siting guidelines, because it's very difficult to site new mental health facilities, they didn't think this could be done.

Mr. Stinson: This is a bold and radical change. The residential proposal is a smaller item. Certainly the Mental Health Board will work on helping to come up with arguments to support you in going forward with this. Especially in the context of the homeless programs.

Mr. Douglas: When I looked at this wearing my hat as a Mental Health Board member I'm all in favor of it, but as a citizen, I'm wondering if it is not a dangerous trend to have the whole budget set aside, because then the Board of Supervisors won't be able to do the job we're paying them to do which is to manage the city. If we keep going in this direction, pretty soon 95% of the budget will be set aside.

Supervisor Daly: I think that's the most significant concern about this charter amendment. There is a very sound policy issue against set asides.

However, this is not a set aside, but a baseline budget. A set aside will take a certain percentage of the property tax and set that aside. A baseline looks at the budget in a certain moment of time and freeze that. It would be set by last years dollar amount. It does lock us into that level of commitment.

If we are going to lock any department in, I think there is a strong policy argument to make it be the Health Department which provides services for our most vulnerable populations. If we are going to have set asides for the Opera, doesn't it make sense to guarantee the everyday health of San Franciscans? Also the cost of health care has been going up faster than the rate of inflation in the economy. This baseline is very conservative.

There is an opportunity within the budget process for the Mayor and Board of Supervisors to increase the commitment to DPH, but they couldn't decrease the budget.

We had long hearings last year, we were there till 2 or 3 a.m. listening to people with fears about their services being cut and what would happen to them.

I am worried that this next year is going to be a tough budget year and we might not be able to put money back into the budget like we did this last year. I'm not sure I can save programs without an amendment like this.

I'm hoping to have a hearing in front of the Health Commission.

SWEARING IN OF BOARD MEMBERS
Supervisor Hall: I want to say thank you to Supervisor Daly for what is a good presentation of his legislation. I'd like to underscore the intent of that legislation tonight. Nothing is more stressful than trying to support the mental health of a modern American city. We need to zero in on people like you who are on the front lines for your input. I want to help Supervisor Daly where I can with this amendment.

I wanted to come here tonight and thank you personally for the effort you've made in being part of this Board. Myself, my staff, and the whole Board of Supervisors thank you for what you do. Many of our constituents do not know what you do. All we can do is say thank you. My office and Supervisor Daly's office are willing to support you however we can.

Congratulations and God bless you!

I'd like to ask you all to stand, raise your right hand, and repeat after me:

> I (member's name), do solemnly swear (or affirm) that I will support and defend the Constitution of the United States and the Constitution of the State of California against all enemies foreign and domestic, and that I will bear true faith and allegiance to the Constitution of the United States and the Constitution of the State of California, that I take this obligation freely, without any mental reservation or purpose of evasion, and that I will well and faithfully discharge the duties upon which I am about to enter and during such time as I hold the office of member of the Mental Health Board.

Congratulations!

(Return to original agenda order.)
1.0 CALL TO ORDER AND CONSENT CALENDAR

Mr. Stinson: I want to introduce Dr. Jimmy Jones, the new Medical Director of Community Behavioral Health Services. He's a psychiatrist. He went to medical school in Michigan, and received his psychiatric training at UCSF. He's worked as a consultant for the City and as Medical Director for Baker Places. He worked at Kaiser for two years, and recently decided to come back and work with the City.

1.2.a RESOLUTION (MHB-2003-21): Be it resolved that the minutes of the Mental Health Board meeting of September 10, 2003, be approved as submitted. (Passed unanimously.)

1.2.b RESOLUTION (MHB-2003-22): Be it resolved that the Mental Health Board grants leaves of absence for the meeting of October 8, 2003, to the following members: Supervisor Bevan Dufty, Rebecca Turner, and Dennis Yun. (Passed unanimously.)

2.0 PRESENTATION: JUVENILE PROBATION

Ms. Tucker: I want to give you an overview of the Juvenile Probation Department. Youth Guidance Center is the building, but the department is Juvenile Probation for which I am the Chief Probation Officer.

We're building a new detention center. We have Log Cabin Ranch, a residential center in La Honda. We have out-of-home placement. We have probation officers for youth being supervised within the community.

We are responsible for all youth involved in the justice system. We contract with over 50 community based organizations to deliver services to youth and their families.

We are the only institution across the county, like other juvenile probation departments, which cannot reject our clients. Their eligibility is mandated by law. We get the clients who fail all the other systems, and we are the organization that stops their free fall. We look at ourselves as the second or last chance. We detain those we must, we divert those who we can. So when you come to the detention center and you spend time there, you usually have a very serious felony or you are waiting for out-of-home placement.

Those individuals who are hard to place, of course, are those with mental health problems. When we talk about mental health we tend to focus on adults. I've worked with adults. We try to work collaboratively with the Department of Human Services and the Department of Public Health to get the services we need for our kids.

Some of the barriers that we have to providing service for youth in the juvenile justice system, is that there is a severe lack of high level residential treatment facilities or even a state hospital for adolescents. That means that those youth who come to us don't get the kind of services they need, because the programs they need are not there.

Sometimes their criminal actions are due to their mental illness, and so they should not be in juvenile hall in the first place. Also, our counselors are not trained to service kids with mental health problems. I am trained as a psychologist. I stopped doing that work because I wanted to stop dealing with mental health, but here I am working with mental health again.

I switched from working with adults to working with kids because with them there is hope. We don't treat our children too well.

For example one young man who was 15 years old, no one knew where his mother and father were. He was unwanted. He was clearly combative. He fought all the counselors. We have to be careful, there are regulations about how we restrain kids, but our staff cannot be battered. If a child is on suicide watch, we have to watch them every five minutes, and take all their clothes from them, but that is demoralizing.

We have SPY, but we cannot force them to take medication. And there is no hospital that will take combative teens. We sent this particular young man to McAuley, but he attacked a nurse, so they called us and said, Come get him now. He came back and battered three of our counselors who were out for months.

There are no services. Seneca has decided that they don't want to do business with San Francisco anymore. By the end of the year they are out. What do we do then? The more these young people stay with us, the more trouble they get into, and we are considered peace officers. The District Attorney does not add charges to these kids records. And we support that, but then it's tough because my staff get hurt. We've had people who have been out for a year.

We are part of the Children's System of Care, run from Mental Health. That needs to be changed. It's a very rigid bureaucratic system. They assess the kids to death. It can take months. We need a quick evaluation. Then we need services quickly. We need to find out from the kids themselves about what they need. We tend to think people with mental health issues don't know what they need, but excuse me, they know. We need to ask the people, What would help you? Those kids could tell you better than anyone sitting at this table.

We have a long standing disconnect between the youth and the adult mental health system. When the kids get to their placement, does the service get to them? No it doesn't. So the kid is not stabilized. So they fail the placement. So what happens to the kid? They come back to YGC. The kids need wraparound services. We need a team that goes out and provides the services.

When you're talking about the different philosophy from DHS, social workers, DPH, psychology and mental health individuals, then look at the philosophy of juvenile justice. We're law enforcement and social work. Put us all at the same table, and we're not all talking the same language. What is the treatment this kid needs to be able integrate into society?

A lot of times what happens is that we do the assessment, we look at the treatment, and then the treatment doesn't happen. Then to deal with our feeling of guilt we say, This kid should not be incarcerated, this kid should not have consequences for their behavior. But we know that immediate consequences change behavior. When we as professionals finish arguing with each other about the appropriate action, assessing them to death, and not really following through on treatment, then we're not really doing our job. We need more facilities for adults. We need more transitional housing for young people.

Do you remember when de-institutionalization happened? We made community facilities for those individuals. We need to look at the process again. We de-institutionalized people without giving them the care. We need to look at what are the facilities we need to provide in the community. And we need step down from the high level structure. They need ways to step down, gradually removing the structure, so they can function and learn to be productive members of the community. Mental health

problems do not mean that you cannot function in the community, if you have the proper support systems.

Sometimes to work together we need to be in the same structure, and you will duke it out, and come to an agreement with a plan for each child. Sometimes we are like parents fighting over the kids and the kid comes away confused and the parents are even more confused. We need to come together on the cases and have the interdisciplinary case. I'm not saying we don't have this. But we come away from the table with different decisions, and we go into the court with mental health saying one thing and probation saying another. And the poor kid and family are confused. So we need to get our act together.

Also the school district needs to get programs together to meet the mental health needs of students who do not qualify for AB 3622 and yet are serious behavior problems for the District.

One of the things we have done, in responding the needs of these kids is the Rivera Academy, a wrap-around service, a collaboration with Community Mental Health Services, the Department of Human Services, and San Francisco Unified School District and the performing arts workshop housed at Barnett.

There are probation officers on staff, mental health staff, DHS social workers, teachers, and artists, who offer a unique learning environment for kids in the juvenile justice system and who are at high risk for out-of-home placement.

The school goes from early morning, they are picked up at their home, and they don't go home till 8 in the evening. The parents are involved. Some of parents said they had never seen those kids produce like they did in that school. Parents were involved like never before.

We have a high school on this order now, Impact High School. There is individual and group therapy and case management. Psychoeducational evaluations are completed within one week, not three months. Then we begin the services immediately. This is a small project funded by us and some additional money.

Also we have a collaboration with Walden House which identifies youth with substance abuse issues. They are detained, but then transported to Walden House to participate in treatment with their families.

This is what we are doing because we have such trouble getting appropriate services for our kids.

We have SPY at juvenile hall which is through DPH. And DHS is there as part of the multi-disciplinary team.

We are endeavoring to meet the needs of our kids, but the need is so much greater. SED kids in the general population is 9-13 %. But in the juvenile justice system they are 20+%. These kids are lost, they are in a free-fall, the families are at their wits end, and we don't have the resources available to give the them treatment they need. The judge

wants to see what the plans are and what the services are. On many occasions the judge has cited the Community Mental Health Services of the Department of Public Health for not delivering services, especially in grievous situations.

There was a young man, self-mutilating every day. It was so very serious. He had to be stripped. There could be nothing in his room. If we gave him a book he would take the staple out and excuse me, I have to be graphic, and jam it up his penis. We had to take him to SFGH all the time. We had to watch him all the time. We had to sit at his door constantly. We took him to court. We could not find a place for him.

He was at McAuley, I think. We had to send him to CYA, because CYA could control him and they could medicate him. We could not 5150 him, because he did not qualify, but we knew if he continued to self mutilate, he was going to kill himself. We had to take him to California Youth Authority. He should not have been there. His charges are serious, they were sex charges, so there was not a way for us to put him in the community. But do you see the double bind? There was not a place to take him that was appropriate. If this were an adult we could have placed him.

The facilities are not available that we need for treating juveniles. Another jurisdiction I worked in was sued for this reason, that adults were provided services that youth were not.

Dr. Moses: I want to congratulate you on your new appointment. Could you give us the statistical and geographical location of where your clients are from? When your clients reach 18, are they still your clients or do they go somewhere else?

Ms. Tucker: That's exactly what I'm saying, when they age out of our system at 18, or with a special order of the judge at 21, there is a difference in how youth are handled vs. adults.

Our staff take the battering, but you don't see the adult correctional officers take the battering, and they have the mental health clinic right there, so the inmate can be transferred in there.

Most of our clients we have are from San Francisco. For those who are in probation in the community, the highest number are in zip code 94124 , Bayview, second highest is 94134, Visitacion Valley, third highest is 94112, Ingleside. Then 94110, Inner Mission and 94115, Western Addition.

One of the things we're trying to do is juvenile detention alternatives. One initiative is underwritten by the Annie E. Casey Foundation. We're looking at the disproportionate minority confinement concerns.

Mr. Luebkeman: Regarding the new Youth Guidance Center, I know it's been controversial. From your perspective, what will the new facility do for the kids who will be there?

Ms. Tucker: It's going to be so wonderful The facility we have now is not conducive to rehabilitation. If you go into one of our units, you'll see they are made like a cross. On

one side of the unit are the counselors. Then there are rooms down the halls, but you can't see what's going on. In the new facility, there are two tiers, so the staff can view everyone in a semi-circle. There will be an acre of outside greenery. We'll have inside facilities for rainy day activities, plus other space for programming.

We'll have central control for security. Our present infrastructure does not allow for the best security. There will be a control station that will control all external doors. There will be sally ports. We won't let them out of the car outside and kid won't have an opportunity to run into the neighborhood. We have built into the new facility the ability to have an infirmary. We are working with DPH to equip that infirmary so we don't have to take kids to SFGH. We are also looking at including a mental health unit.

There are only 18 more beds in the new facility. But in San Francisco our philosophy is to provide alternatives. Since January our population has been between 80 and 90. Right now it's up to 111 because there is a surge when kids go back to school. We have spent three years designing this facility. Kids can go from one place to another watched by central control and not have to be in handcuffs.

Mr. Douglas: I used to be a social worker. Are you getting nonprofits to get involved? Ms. Tucker: We have that now with over 50 nonprofit organizations we contract with in prevention and rehabilitation for clients and families.

Mr. Douglas: You have unmet needs. Are you able to develop resources to take care of those? Ms. Tucker: Our biggest unmet needs are in the area of youth who need mental health services. This is our largest problem. The rest of it we have been able to deal with. The other area of concern is girls and we have been able to develop gender specific services. Now our biggest challenge is meeting the needs of our clients with mental health issues.

3.0 DIRECTOR'S REPORT

3.1 Report from the Director of Community Behavioral Health Services

Dr. McConnell reported for Dr. Robert Cabaj: There's not a lot new on the budget. The main thing is the election of the new Governor. A lot of the mental health money comes form the Vehicle License Fee which the new Governor opposes. Already today the battles are beginning.

Budget Update. The FY03-04 budget has been approved by the Mayor's Office, as was previously reported. A major concern, however, is the outcome of the Governor's election and whether or not the vehicle license fee will be repealed or scaled back. The Mayor's Office is already raising concerns about the state of the budget and this will exacerbate the problem significantly, and may result in mid-year spending reductions. In terms of the FY04-05 budget, Community Behavioral Health Services (CBHS) will begin discussions during the month of October.

Sam Ammons. We are recognizing Mr. Sam Ammons, Sr. Psychiatric Orderly at Mission Mental Health Services, for fifty (50) years of service to the City of San Francisco. Mr. Ammons began working for the City in 1953; he worked on inpatient units and the Psychiatric Emergency Service at San Francisco General Hospital and at

Laguna Honda Hospital. Starting in 1972, he began working for Mission Mental Health Services. We thank him for these many years of dedication. We congratulate him on his 50th anniversary with the Department of Public Health and celebrate his desire to continue to contribute his talents and energy to the mental health of the residents of San Francisco.

Systems of Care Collaboration: A National Movement to Improve Child & Family Outcomes. On September 19, 2003, the Children, Youth and Family System of Care for Community Behavioral Health Services presented a symposium on the "Systems of Care Collaboration: A National Movement to Improve Child & Family Outcomes." The Symposium is supported by generous contribution from the Annie Casey Foundation. The Symposium featured a keynote address by Bill Bettencourt, Team leader for California, Family to Family Initiative, Annie E. Casey Foundation, on "Collaborating to Meet the Needs of Children, Youth and Families: A National Movement."

An interagency panel presented on the multiple reform initiatives to improve the lives of Children and Families. The panel included Gwen Chan, Chief Development Officer, San Francisco Unified School District; Gwendolyn Tucker, Chief Probation Officer, Juvenile Probation Department; Janice Anderson-Santos, Deputy Director, Family and Children's Services Division, San Francisco Department of Human Services; Cynthia Billups, Coordinator, Children System of Care Family Involvement Team; Alan Fox, Safe Start Coordinator, Department of Children, Youth and Their Families; Agnes Briones, Director of Services Integration, Mayor's Criminal Justice Council; and Sai-Ling Chan-sew, Director of CYF System of Care, Community Behavioral Health Services. In the afternoon, David Osher, Director of the Center for Effective Collaboration and Practice for the American Institutes for Research, presented a paper on the "Collaboration and Improved Outcomes in the Public School, Child Welfare, Behavioral Health, and Juvenile Justice Systems: Use of Evidence-Based Practices, a National Trend." The Symposium closed with a performance by the CSOC Youth Task Force. The Symposium was attended by 150 participants.

Children, Youth and Family System of Care 2003 Annual All Staff Meeting. On September 25, 2003, Children, Youth and Family System of Care presented the 2003 Annual All Staff Meeting at Fort Mason. It was the first All Staff Meeting held for the staff and contractors from both Community Mental Health Services and Community Substance Abuse Services. It was attended by over 350 participants. Darryl Inaba, Pharm. D. and CEO of the Haight-Ashbury Free Clinic, gave the keynote speech on the development of integrated services for adolescents from a local and national perspective. The importance of incorporating consumer input into treatment planning was discussed. Recommendations from the CSOC Youth Task Force were shared with providers, and the publication by the Federation of Families for Children's Mental Health on Treatment Experiences of Youth with Co-occurring Substance Abuse and Mental Health Disorders and their Families, titled " Blamed and Ashamed" was distributed to all participants. The CYF Annual Report on mental health and substance abuse services was also distributed to participants.

San Francisco Practice Improvement Collaborative (PIC). The San Francisco Practice Improvement Collaborative (PIC) is a community-planning group convened in 1999 through a CSAT grant to the San Francisco Department of Public Health. Through this

grant, providers, researchers, and policy makers collaborate to share ideas, information, and resources to improve the quality of substance abuse treatment and prevention services.

The SF-PIC Family Interest Group emerged as PIC members identified interests that are very specific to sub-population groups. Interest group members recognize the negative impact of substance abuse on their neighborhoods and specific populations, particularly African Americans in Bayview-Hunterís Point. Drug use is something many families in this community experience directly or indirectly, yet few people in these desperate situations have accurate understanding of addiction and drug impact. Equally important, they oftentimes do not have any strategies to contribute even to a micro solution.

After discussions, drug education was identified as a priority need for communities plagued with drug use and violence. Historically, needed social change and social movements in the African American community have come out of the faith community, thus the Family Interest Group has developed a partnership with local churches, substance abuse treatment providers, and recovery community members to bring addiction information and treatment options to the family and community.

The SF-PIC Family Interest Group began this collaborative process by identifying members of a drug education team. When selecting providers, SF-PIC staff identified two treatment programs that are culturally appropriate and familiar with the character, protocol, and history of the Black Church. Staff From Walden House and Positive Direction Equals Change were invited to participate and have graciously volunteered their time. This team is comprised of members who are culturally competent and well versed in church and community dynamics.

CBHS data and community feedback indicates that African American are disproportionately represented among CSAS clients. Cocaine, heroin, alcohol, and marijuana are the primary drugs of choice for clients from BVHP. Consequently, SF-PIC staff worked with the Community Drug Education Team to develop drug fact sheets that are comprehensive, yet community friendly. SF-PIC staff approached two churches to pilot the project. The first participant for the trainings was Metropolitan Baptist Church. They were scheduled for two Friday night trainings.

Metropolitan Baptist Church has a membership of approximately 100 members. The pastor has shown himself to be a true visionary and willing to work with partners from all sectors of society in order to improve community outcomes. Meetings with the church leadership led to the selection of Friday evenings, 7:00-8:30, as the time period for the trainings. This is a time many churches hold family focused activities and also worked best for the Drug Education Team. Cocaine and alcohol were selected as the first topics to be addressed in the trainings. These were drugs that the church leadership believed were directly affecting members and/or their families.

Approximately 25 participants attended each training. Each session was preceded by a light dinner, donated by Drug Education team members & the host pastor. SF-PIC staff welcomed the participants and shared background information regarding SF DPH and the SF-PIC. A brief video clip on community response to drugs & violence is shown

and then the Drug Education Team begins to share information regarding addiction as a disease and the physiological and psychological impact of drug use. Team members than discuss local treatment options and the "process" for acquiring treatment in San Francisco. The recovery community member concludes the presentation with personal testimonials from her addiction period and the successes and challenges of living a clean and sober life. The training is then concluded with a Question & Answer session (although some questions are entertained throughout the presentation).

These trainings have proven to be life changing for the attendees and trainers. With the skill, knowledge, and charisma of the trainers, individuals and families are empowered to ask questions, build relationships with providers and community members, and take information home to distribute to family and friends. Response has been overwhelming and satisfaction is high. Metropolitan church members are interested in future trainings and have made the commitment to attend upcoming sessions at other faith community sites.

Next steps of this pilot project are to schedule the trainings for a larger church in Bayview-Hunters Point. The SF-PIC is currently in discussion with Providence Baptist Church, a church with a membership of 500-600. The SF-PIC is also exploring the possibility of using SF-PIC grant carry-forward funds to support these types of education trainings throughout Bayview-Hunters Point.

The SF-PIC is also considering providing motivational interviewing training to pastors in Bayview-Hunters Point. These leaders have experience in counseling techniques, but have limited knowledge of how to use motivational interviewing techniques while counseling members regarding addiction and drug use. It is believed that training in this area will lead to a greater identification of substance use in their congregations and communities. With this information, referrals can be made to Walden House and PDEC for further assessment and placement.

New San Francisco Community Clubhouse. Under new management, the former Bayview Clubhouse has re-designed its program into a Wellness-Recovery Center, now called The San Francisco Community Clubhouse, effective July 1, 2003. Still based on the principles of the Fountain House model pioneered in New York City in the 1940s, the Clubhouse helps people with mental illness achieve their potential by promoting self-help and peer support; self-sufficiency; and the therapeutic value of meaningful work, feeling needed, and belonging to a community. The Clubhouse embodies the philosophy that individuals can and do recover.

The target client population for the San Francisco Community Clubhouse includes individuals who have been diagnosed with chronic and persistent mental illnesses, now stable on medications, and ready for further recovery through participation in a program focusing on the development and enhancement of pre-vocational and social skills. Activities and services in the Clubhouse include:

The Consumer Resource Center, providing members with direct access to information to a variety of services and activities that may be useful in their recovery process.

Group therapy and support, facilitated by staff, peer counselors, and members of the Clubhouse, including Vocational/Educational, Wellness-Recovery, Relapse Prevention, Drama, Social Skills, Psycho-Education, Art/Poetry/Music, and Movement support groups.

Vocational experiences including participation in the following work units: Reception, Thrift Store, Food Service, Clerical, Operations, and REM (Research, Education & Media).

Training in development of individual Wellness & Recovery Action Plans.

Recreational activities and informal activity groups.

Medication support services provided in collaboration with the Tenderloin Outpatient Clinic.

The Clubhouse is at the forefront in San Francisco of integrating Recovery principles into the delivery of behavioral health services. For more information about the program, contact Program Director, Cindy Gyori, at (415) 673-5700.

Child and Adolescent Dual Diagnosis: Clinical Dilemmas in Assessment and Treatment. This training is scheduled for October 16, 2003 and is sponsored by the Child, Youth and Family System of Care, the Health Promotions Section and Title IV-E.

Working in Recovery: Ethical and Personal Challenges Facing the Treatment Workforce. This training is scheduled for November 19, 2003. It is presented by the San Francisco Practice Improvement Collaborative of Community Behavioral Health Services, and is funded by the Center for Substance Abuse Treatment, the Substance Abuse and Mental Health Services Administration, and the Charles and Helen Schwab Foundation.

Debriefing Activities. There was an unusually high incidence of gun-related death and suicide during the month of September. Although none of the victims were opened in our system when the incidents took place, Child Crisis was nonetheless helpful in debriefing activities with students and staff to help them cope with the tragedies. 9/4/03 Debriefing at John O'Connell High School due to a completed suicide. 9/22/03 Debriefing at Pacific Center Day Care due to the natural death of an infant. 9/22/03 Debriefing at Luther Burbank Middle School due to the gun-related death of a former student. 9/23/03 Debriefed at Luther Burbank Middle School for same reason. 9/23/03 Debriefed at Philip Burton High School due to death of student (same student at Luther Burbank). In addition, on Sept. 1, Child Crisis begun their PTSD treatment program and the referral process is in place and active.

Dr. Moses: I want to commend CBHS for sympathizing with Bay View residents. I'm glad to read about these services. I hope they will continue to be there long-term, not just on an experimental basis. I really appreciate it, because it's been needed for a long, long time. I hope you establish something for family crisis intervention in the Bay View. When someone 's child dies, people need help there in the community, immediately.

With regard to advisory board integration, can you brief us on that or can we calendar that for the future?

Ms. Brooke: Because we are now Community Behavioral Health Services, the administration of DPH is looking at ways to consolidate the work of the advisory boards. Toye, Augusta, and Bob attended a meeting with the Treatment on Demand Council on integration.

Mr. Stinson: This is a topic that has come recently on the radar screen, and it's not entirely clear what's going to happen. It's a topic that the boards will be discussing. Dr. Moses: Could we ask someone who's familiar with consolidation to come talk with us about this?

Mr. Douglas: We heard the Chief Probation Officer say they are having trouble getting mental health services for our kids. Could you tell us about that? Dr. McConnell: I don't know the answer to that. You might want to have Sai-Ling Chan-Sew come talk with you and get her perspective.

3.2 Report from the Executive Director of the Mental Health Board
At the request of the Board, Mr. Snowdon made a brief presentation on the budget of the Mental Health Board. It was requested that a budget report be made again in April.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee
Mr. Stinson: AB 1421 will be discussed at next meeting. You've each received a handout with arguments on both side of the legislation. This is probably one of the most challenging and substantive issues the Mental Health Board has tackled in the last couple years.

Mr. Douglas: Is the City considering implementing AB 1421? Mr. Stinson: Yes, there has been discussion of that in the context of the mayoral race. Ms. Brooke: I spoke with Cathy Garza, a staff person for Supervisor Newsom. They are looking into AB 1421, but the issue has not been calendared.

Dr. Moses: I want to thank Helynna and her staff for putting all this information together for us, for always sending things out in record time. I thank them.
Mr. Stinson: We are incredibly blessed and fortunate to have Helynna and Rich as our staff.

Mr. Stinson: Bob Douglas went to the meeting of the California Association of Local Mental Health Boards (CALMHB) in San Jose.

Mr. Douglas: It was very interesting. They were concentrating on the issue that in some counties the public guardian is misspending clients' money. CALMHB is going to look into this. The next meeting will be at the San Francisco airport in January. A new thing from federal government is accountability. Programs have to be backed by research proving that they work.

Mr. Stinson: We have a resolution tonight on the Behavioral Health Court.

mr. martin: I missed the last meeting. When Judge Kahn came to the Board and made the original presentation, I had one question, What are the performance criteria and standards and what schedule are you going to do evaluations on? And Judge Kahn said that they did not have such standards in place, and they were planning on developing them because they were going to pursue private sector funding. That's a wrong-headed way to do it. It's important to develop standards for working with clients, not standards to make funders happy. I would like to table this motion. I think Behavioral Health Court is inevitable, but I want to make sure it's done well.

Mr. Luebkeman: It's a shame you missed the presentation. This is a way to get people with mental illness out of the criminal justice system and the alternatives are callous. It was a compelling and heart-warming presentation. I remember she did make one reference to a grant she had gotten. It was a small point.

Ms. Walker: I would like to second that we table it. I heard Judge Breall speak and I thought she was marvellous, but it's a new program. I think that it would be better that we spend time on programs that work.

Dr. Moses: The judge made a wonderful presentation. If you look at the resolution, it's to commend the Court and promote increased funding. I think it's very positive.

Mr. Stinson: I personally feel like what were are making is a philosophical statement of support, not one that is unqualified. We're not saying that we won't continue to monitor the Court. To take speople out of the criminal justice and into mental health, I think that is a good thing. This is not a blank check.

mr. martin: Then what is the rush? Ms. Walker: Right.

Mr. Luebkeman: I don't want to ram this through, but I don't want to table it indefinitely. Mr. Stinson: This is the second time we've heard about the Court, and I think we could move ahead now.

Ms. Walker: I disagree with the philosophy behind the Court. Judge Kahn said that people forced into treatment with sanctions are more likely to be successful than those who walk in off the street to a facility and ask for help. Judge Breall spoke very well. If she were handling it, marvellous. She gave an example of a young woman who said she hadn't taken her medication for a long time. And her case manager was surprised. And then Breall said to the woman will you agree to take your medications? It seems like if the client was doing fine without the mediaction, so fine that she fooled her case manager, what are we doing, saying we think this is what you should do. If you don't do what we think is best for you, then there are sanctions. I think we are forcing people to do things that they themselves know are not good for them.

Dr. Del Zotto: The resolution itself is a very general resolution. There is still a lot of room to debate the issues.

Mr. Luebkeman: I can appreciate the desire of Chance to get clear guidelines, and the need to go back to the Court for information about that. But Judge Breall said each case is so unique that I think you might be hard pressed to measure what success is.

mr. martin: There are outcome measures. When Judge Kahn was talking about the stick and carrot approach to working with clients, without addressing outcome measures, it's taking a cavalier approach to people's futures. I'm going to sit down with our attorney tomorrow, and fill out a freedom of information act regarding the Behavioral Health Court to get information. If I do the FOI tomorrrow, I'll have the answer soon. I move to table this resolution till the November meeting.

RESOLUTION (MHB-2003-23): Be it resolved that the Mental Health Board tables its resolution on the Behavioral Health Court until its meeting on November 12, 2003. (Passed.) For the resolution: Ms. Brown, Dr. Del Zotto, Ms. Knight, Mr. Luebkeman, mr. martin, Ms. Schaffer, Ms. Yuen. Opposed to the resolution: Mr. Douglas, Ms. Leung, Dr. Moses, Mr. Stinson, Ms. Wilson.

Ms. Shaffer: The Program, Services, and Children's Committee met and had Victor Damian do a presentation on transitional youth. I was blown away, it was something else. I go to a lot of different meetings, but this was very powerful. I want to do whatever we can to support the Youth Task Force. We could invite him to speak to the full Board.

6.0 NEW BUSINESS

Mr. Douglas: Can the Department tell us how they are working with the people at Juvenile Probation?

Dr. Moses: Can the staff who knows about the consolidation of the advisory boards come and answer questions? The priority for the next meeting is to go over the charter amendment. I hope Supervisor Daly's staff will be here. mr. martin: We can get the report from the Rules Committee after they hear the issue.

Mr. Luebkeman: There's a lot on our plate for the next meeting. There's plenty to time to discuss this charter amendment before it goes before the electorate.

Ms. King: Thank you for inviting me to this meeting.

Mr. Stinson: This has been a very full, very rich Board meeting.

7.0 PUBLIC COMMENT

Mr. Kalman: I would like the Board to invite Jeff Adachi, the Public Defender, to do a presentation.

There being no further business, the meeting was adjourned at 8:32 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, November 12, 2003
1380 Howard, Room 537
6:30 p.m.

AGENDA

Public comments will be taken for each agenda item.

1.0 CALL TO ORDER AND CONSENT CALENDAR (5 minutes)
For discussion and proposed action.

1.1 Call to Order and Announcements from the Chair

1.2 Consent Calendar

1.2.a PROPOSED ACTION: Be it resolved that the minutes of the Mental Health Board meeting of October 8, 2003, be approved as submitted.

1.2.b PROPOSED ACTION: Be it resolved that the Mental Health Board grants leaves of absence for the meeting of November 12, 2003, to the following members: Augusta Del Zotto, Toye Moses.

2.0 PRESENTATION AND DISCUSSION: AB 1421 and BEHAVIORAL HEALTH COURT (50 minutes)
For discussion and action.

AB1421: DPH Representative to present departmental cost analysis regarding implementation of AB1421. Discussion of pros and cons.

Behavioral Health Court: discussion

3.0 DIRECTORS REPORTS (25 minutes)
For discussion.

3.1 Report from the Director of Community Mental Health Services
A report on the activities and operations of Community Mental Health Services, including budget, planning, policy, and programs and services.

3.2 Report from the Executive Director of the Mental Health Board
A report including updates and announcements regarding the activities and operations of the Board.

4.0 MENTAL HEALTH BOARD COMMITTEES (30 minutes)

For discussion and proposed action

4.1 Report of the Chair of the Board and Executive Committee
The Chair will report discussions and actions of Executive Committee. Discussion of budget policy and strategy.

4.2 PROPOSED ACTION: Be it resolved that the Mental Health Board takes a position of support for the Behavioral Health Court. (Attachment A)

4.3 PROPOSED ACTION: Be it resolved that the Mental Health Board takes a position of support for the Mental Health Services Act (Attachment B)

5.0 NEW BUSINESS (5 minutes)
Suggestions for future agenda items or issues the Board might consider looking into.

6.0 PUBLIC COMMENT (5 minutes)
This is an opportunity for members of the public to address the Mental Health Board on items of interest to the public that are within the subject matter jurisdiction of the Mental Health Board. Additionally, public comments will be taken for each agenda item.

This agenda and all attachments can be viewed at: www.sfgov.org/mental_health. Agendas and attachments are also available at the Mental Health Board Office, 1380 Howard Street, Suite 510, telephone 255-3474.

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MENTAL HEALTH BOARD
ATTACHMENT
November 12, 2003

PROPOSED RESOLUTION (MHB-2003-xx):
IN SUPPORT OF THE BEHAVIORAL HEALTH COURT

WHEREAS, far too many people with mental illness end up in the criminal justice system rather than in the mental health system, and

WHEREAS, these people with mental illness need treatment rather than punishment, and

WHEREAS, the newly-developed Behavioral Health Court is proving itself to be a very effective and humane way to help mentally ill offenders get into treatment, and

WHEREAS, the Behavioral Health Court involves a multidisciplinary team and is an excellent role model for the coordination and integration of services across City departments, and

WHEREAS, the Behavioral Health Court helps keep clients from falling into the cycle of recidivism, and

WHEREAS, the Mental Health Board has had two presentations on the Court, one by Judge Harold Kahn on January 8, 2003, the first day of operation for the Court and one on September 10, 2003, a nine-month follow up by Judge Susan Breall, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board commends the City and County of San Francisco for creating and supporting the Behavioral Health Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Superior Court of the City and County of San Francisco, and especially Judges Kahn, Breall, and their colleagues for their strong commitment to the Court and their compassion for the clients of the Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to make it a priority to increase funding and support for the Court, so the Court can increase the number of clients it works with..

MENTAL HEALTH BOARD
ATTACHMENT
November 12, 2003

In this attachment you will find the home page of the website for the Mental Health Services Act in case you would like further information, along with a copy of the full text of the Act.

PROPOSED RESOLUTION (MHB-2003-xx):
IN SUPPORT OF THE MENTAL HEALTH SERVICES ACT

WHEREAS, there is an urgent need for additional mental health services for children and adults in the state of California, and

WHEREAS, there is significant concern about the funding for mental health services through the Vehicle License Fee (VLF) being discontinued in the near future, and

WHEREAS, the Mental Health Services Act provides an appropriate funding mechanism for providing needed services through the statewide initiative process, and

WHEREAS, the Board of Supervisors of the City and County of San Francisco has unanimously adopted a resolution put forward by Supervisor Gavin Newsom in support of the Mental Health Services Act, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board commends and thanks Supervisor Newsom and the entire Board of Supervisors of the City and County of San Francisco for being the first county Board of Supervisors in the state to support the Mental Health Services Act, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the Mayor of San Francisco to add his official support to the Mental Health Services Act and to instruct the Sacramento lobbyist for San Francisco to lobby strongly on behalf of this Act.

Campaign for Mental Health

A Coalition of Community Mental Health Providers, Concerned Families, and Supporters

Monday, November 03

News

10/06/2003
Mental health care for kids varies widely by state

by Marilyn Elias, USA TODAY

Whether a child gets mental health care depends a great deal on where he lives, according to a study released today. It is the first to examine geographic differences in children's treatment.

A child in Massachusetts is more than twice as likely as a similarly needy child in California to get care, the RAND survey of 45,247 parents shows.

USA Today Link

Full Story

09/22/2003
Proposed mental health initiative battles 30 years of neglect

San Diego City Beat

by Kelly Davis

A year and a few weeks from now, California voters may be given the chance to tax the rich in order to solve the state's mental healthcare problems.

The Mental Health Services Act, as proposed for the November 2004 ballot, would adopt somewhat of a Robin Hood approach to ensure public mental health programs have proper funding. The initiative would levy a 1 percent tax on California residents with a net income, after deductions, in excess of $1 million. Only each dollar earned above $1 million would be taxed. For example, a person earning $1.5 million would be taxed 1 percent of $500,000. Roughly 29,000 Californians—with an average income of $5 million among them—would pay the tax.

SD City Beat web site

Full Story

09/15/2003
Cause of Death: Suicide. Age: 8

People Magazine

Angela Gutierrez's self-inflicted death in the third grade rasies a disturbing question: Why are more preteens taking their own lives?

Download this PDF copy of the People Magazine article from 9/15/03.

People magazine Article

Full Story

See Other Recent News Stories

You can contribute: Info for 501 (c)(3) orgs.

You Can Contribute: information for 501(c)(3) organizations.

Clarification of Ballot Measure and Signature Gathring Contributions by 501(C)(3) Nonprofit Agencies.

Contribution Rules for 501(c)(3) organizations.

What a 501(c)(3) Organization can do.

Summary

The Mental Health Services Act is a proposed citizen initiative expected to appear on the November 2004 ballot. The initiative expands mental health care programs for children and adults. It provides services to persons currently disabled by mental illness, persons showing signs of mental illness in need of prevention services, and to families and caregivers of those affected. For most adults, the initiative used the recently developed, successful "integrated services" model to link many kinds of care.

The initiative pays for expanded programs through a surcharge on income above $1 million per year. A new 1% surcharge applies to each dollar earned over $1 million. The initiative creates a new oversight and accountability commission to supervise the new mental health care programs.

Please look under "Facts" to learn more about the initiative.

Read the Attorney General's Title and Summary

Read the Full Text

Signature Gathering

If you'd like to help gather Signature to Qualify this Initiative for the ballot, please download and read these documents

Signature Gathering

Circulators Affidavit

Circulator Guidelines

Circulator Rules

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We need your finanacial support now. Please take a moment to contribute to this campaign.

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Endorsements

Board of Supervisors of the City and County of San Francisco
web site

Mental Health Association of Orange County
web site

California Network of Mental Health Clients
web site

Service Employees International Union - California State Council
web site

Congress of California Seniors
web site

Association of Community Human Service Agencies

California Academy of Child and Adolescent Psychiatry
web site

California Alliance of Child and Family Services
Web Site

California Psychological Association
web site

NAMI - California
web site

National Association of Social Workers, California Chapter
web site

Mental Health Association in Los Angeles County
web site

Mental Health Association in California
web site

United Advocates For Children of California
web site

California Council of Community Mental Health Agencies
web site

American Federation of State, county and Municipal Employees, AFL-CIO of California

California Mental Health Planning Council
web site

California Mental Health Directors Association

MENTAL HEALTH SERVICES ACT

SECTION 1. Title

This Act shall be known and may be cited as the "Mental Health Services Act."

SECTION 2. Findings and Declarations

The People of the State of California hereby find and declare all of the following:

(a) Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children — between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

(b) Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

(c) Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

(d) In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

(e) With effective treatment and support, recovery from mental illness is feasible for most people. The State of California has developed effective models of providing services to children, adults and seniors with serious mental illness. A recent innovative approach, begun under Assembly Bill 34 in 1999, was recognized in 2003 as a model program by the President's Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self-sufficiency for those who may have otherwise faced homelessness or dependence on the state for years to come. Other innovations address services to other underserved populations such as traumatized youth and isolated seniors. These successful programs, including prevention, emphasize client-centered, family focused and community-based services that are culturally and linguistically competent and are provided in an integrated services system.

(f) By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. Cutting mental health services wastes lives and costs more. California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.

(g) To provide an equitable way to fund these expanded services while protecting other vital state services from being cut, very high-income individuals should pay an additional one percent of that portion of their annual income that exceeds one million dollars ($1,000,000). About 1/10 of one percent of Californians have incomes in excess of one million dollars ($1,000,000). They have an average pre-tax income of nearly five million dollars ($5,000,000). The additional tax paid pursuant to this represents only a small fraction of the amount of tax reduction they are realizing through recent changes in the federal income tax law and only a small portion of what they save on property taxes by living in California as compared to the property taxes they would be paying on multi-million dollar homes in other states.

SECTION 3. Purpose and Intent.

The People of the State of California hereby declare their purpose and intent in enacting this Act to be as follows:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

SECTION 4. Part 3.6 (commencing with Section 5840) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 3.6 PREVENTION AND EARLY INTERVENTION PROGRAMS

5840. (a) The Department of Mental Health shall establish a program designed to prevent mental illnesses from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.

(b) The program shall include the following components:

(1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.

(2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Section 5600.3, and for adults and seniors with severe mental illness, as defined in Section 5600.3, as early in the onset of these conditions as practicable.

(3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.

(4) Reduction in discrimination against people with mental illness.

(c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

(d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

(1) Suicide.

(2) Incarcerations.

(3) School failure or dropout.

(4) Unemployment.

(5) Prolonged suffering.

(6) Homelessness.

(7) Removal of children from their homes.

(e) In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults, and seniors.

5840.2 (a) The department shall contract for the provision of services pursuant to this part with each county mental health program in the manner set forth in Section 5897.

SECTION 5. Article 11 (commencing with Section 5878.1) is added to Chapter 1 of Part 4 of Division 5 of the Welfare and Institutions Code, to read:

Article 11. Services for Children with Severe Mental Illness.

5878.1 (a) It is the intent of this article to establish programs that assure services will be provided to severely mentally ill children as defined in Section 5878.2 and that they be part of the children's system of care established pursuant to this Part. It is the intent of this Act that services provided under this Chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.

(b) Nothing in this Act shall be construed to authorize any services to be provided to a minor without the consent of the child's parent or legal guardian beyond those already authorized by existing statute.

5878.2 For purposes of this article, severely mentally ill children means minors under the age of 18 who meet the criteria set forth in subdivision (a) of Section 5600.3.

5878.3 (a) Subject to the availability of funds as determined pursuant to Part 4.5, county mental health programs shall offer services to severely mentally ill children for whom services under any other public or private insurance or other mental health or entitlement program is inadequate or unavailable. Other entitlement programs include but are not limited to mental health services available pursuant to MediCal, child welfare, and special education programs. The funding shall cover only those portions of care that cannot be paid for with public or private insurance, other mental health funds or other entitlement programs.

(b) Funding shall be at sufficient levels to ensure that counties can provide each child served all of the necessary services set forth in the applicable treatment plan developed in accordance with this Part, including services where appropriate and necessary to prevent an out of home placement, such as services pursuant to Chapter 4 of Part 6 of Division 9 (commencing with Section 18250).

(c) The Department of Mental Health shall contract with county mental health programs for the provision of services under this article in the manner set forth in Section 5897.

SECTION 6. Section 18257 is added to the Welfare and Institutions Code to read as follows:

18257. (a) The Department of Social Services shall seek applicable federal approval to make the maximum number of children being served through such programs eligible for federal financial participation and amend any applicable state regulations to the extent necessary to eliminate any limitations on the numbers of children who can participate in these programs.

(b) Funds from the Mental Health Services Fund shall be made available to the Department of Social Services for technical assistance to counties in establishing and administering projects. Funding shall include reasonable and necessary administrative costs in establishing and administering a project pursuant to this chapter and shall be sufficient to create an incentive for all counties to seek to establish programs pursuant to this chapter.

SECTION 7. Section 5813.5 is added to Part 3 of Division 5 of the Welfare and Institutions Code, to read:

5813.5. Subject to the availability of funds from the Mental Health Services Fund, the Department of Mental Health shall distribute funds for the provision of services under Sections 5801, 5802 and 5806 to county mental health programs. Services shall be available to adults and seniors with severe illnesses who meet the eligibility criteria in Welfare and Institutions Code Section 5600.3(b) and (c). For purposes of this act, seniors means older adult persons identified in Part 3.

(a) Funding shall be provided at sufficient levels to ensure that counties can provide each adult and senior served pursuant to this Part with the medically necessary mental health services, medications and supportive services set forth in the applicable treatment plan.

(b) The funding shall only cover the portions of those costs of services that cannot be paid for with other funds including other mental health funds, public and private insurance, and other local, state and federal funds.

(c) Each county mental health programs plan shall provide for services in accordance with the system of care for adults and seniors who meet the eligibility criteria in Section 5600.3(b) and (c).

(d) Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:
  (1) To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
  (2) To promote consumer-operated services as a way to support recovery.
  (3) To reflect the cultural, ethnic and racial diversity of mental health consumers.
  (4) To plan for each consumer's individual needs.

(e) The plan for each county mental health program shall indicate, subject to the availability of funds as determined by Part 4.5, and other funds available for mental health services, adults and seniors with a severe mental illness being served by this program are either receiving services from this program or have a mental illness that is not sufficiently severe to require the level of services required of this program.

(f) Each county plan and annual update pursuant to Section 5847 shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.

(g) The department shall contract for services with county mental health programs pursuant to Section 5897. After the effective date of this section the term grants referred to in Sections 5814 and 5814.5 shall refer to such contracts.

SECTION 8. Part 3.1 is hereby added to Division 5 of the Welfare and Institutions Code commencing with Section 5820 to read:

PART 3.1 EDUCATION AND TRAINING PROGRAM

5820. (a) It is the intent of this Part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the department a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Parts 3, 3.2, 3.6, and 4 of this Division. For purposes of this Part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The department shall identify the total statewide needs for each professional and other occupational category and develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The Mental Health Planning Council shall advise the Department of Mental Health on education and training policy development and provide oversight for the department's education and training plan development.

(b) The Department of Mental Health shall work with the California Mental Health Planning Council so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The Department of Mental Health shall include in the five-year plan:

(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.

(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, Masters Degrees, or Doctoral degrees.

(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.

(d) Establishment of regional partnerships among the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.

(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Parts 3, 3.2, 3.6, and 4.

(g) Promotion of the employment of mental health consumers and family members in the mental health system.

(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).

(i) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

SECTION 9. Part 3.2 Commencing with Section 5830 is added to Division 5 of the Welfare and Institutions Code to read:

Part 3.2 Innovative Programs

5830. County mental health programs shall develop plans for innovative programs to be funded pursuant to paragraph (6) of subdivision (a) of Section 5892.

(a) The innovative programs shall have the following purposes:

(1) To increase access to underserved groups.

(2) To increase the quality of services, including better outcomes.

(3) To promote interagency collaboration.

(4) To increase access to services.

(b) County mental health programs shall receive funds for their innovation programs upon approval by the Mental Health Oversight and Accountability Commission.

SECTION 10. Part 3.7 (commencing with Section 5845) is added to Division 5 of the Welfare and Institutions Code to read:

PART 3.7. OVERSIGHT AND ACCOUNTABILITY

5845. (a) The Mental Health Services Oversight and Accountability Commission is hereby established to oversee Part 3, the Adults and Older Adults Systems of Care Act; Part 3.1, Human Resources; Part 3.2, Innovative Programs; Part 3.6, Prevention and Early Intervention Programs; and Part 4, the Children's Mental Health Services Act. The Commission shall replace the advisory committee established pursuant to Section 5814. The Commission shall consist of 16 voting members as follows:

(1) The Attorney General or his or her designee.

(2) The Superintendent of Public Instruction or his or her designee.

(3) The Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President pro Tempore of the Senate.

(4) The Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly.

(5) Two persons with a severe mental illness, a family member of an adult or senior with a severe mental illness, a family member of a child who has or has had a severe mental illness, a physician specializing in alcohol and drug treatment, a mental health professional, a county Sheriff, a Superintendent of a school district, a representative of a labor organization, a representative of an employer with less than 500 employees and a representative of an employer with more than 500 employees, and a representative of a health care services plan or insurer, all appointed by the Governor. In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

(b) Members shall serve without compensation, but shall be reimbursed for all actual and necessary expenses incurred in the performance of their duties.

(c) The term of each member shall be three years, to be staggered so that approximately one-third of the appointments expire in each year.

(d) In carrying out its duties and responsibilities, the Commission may do all of the following:

(1) Meet at least once each quarter at any time and location convenient to the public as it may deem appropriate. All meetings of the Commission shall be open to the public.

(2) Within the limit of funds allocated for these purposes, pursuant to the laws and regulations governing state civil service, employ staff, including any clerical, legal, and technical assistance as may appear necessary.

(3) Establish technical advisory committees such as a committee of consumers and family members.

(4) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to any officer or employee of state government.

(5) Develop strategies to overcome stigma and accomplish all other objectives of Parts 3.2, 3.6 and the other provisions of the Act establishing this Commission.

(6) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.

(7) If the Commission identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the Department of Mental Health pursuant to Section 5655.

5846. (a) The Commission shall annually review and approve each county mental health program for expenditures pursuant to Parts 3.2 for Innovative Programs and Part 3.6 for Prevention and Early Intervention.

(b) The department may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the Commission or when local programs could benefit from technical assistance for improvement of their plans submitted pursuant to Section 5847.

(c) The Commission shall ensure that the perspective and participation of members and others suffering from severe mental illness and their family members is a significant factor in all of its decisions and recommendations.

5847. Integrated Plans for Prevention, Innovation and System of Care Services.

(a) Each county mental health program shall prepare and submit a three year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following:

(1) A program for prevention and early intervention in accordance with Part 3.6.

(2) A program for services to children in accordance with Part 4 to include a program pursuant to Chapter 6 of Part 4 of Division 9 commencing with Section 18250 or provide substantial evidence that it is not feasible to establish a wrap-around program in that county.

(3) A program for services to adults and seniors in accordance with Part 3.

(4) A program for Innovations in accordance with Part 3.2.

(5) A program for technological needs and capital facilities needed to provide services pursuant to Parts 3, 3.6 and 4. All plans for proposed facilities with restrictive settings shall demonstrate that the needs of the people to be served cannot be met in a less restrictive or more integrated setting.

(6) Identification of shortages in personnel to provide services pursuant to the above programs and the additional assistance needed from the Education and Training Programs established pursuant to Part 3.1.

(7) Establishment and maintenance of a prudent reserve to ensure the county program will continue to be able to serve children, adults and seniors that it is currently serving pursuant to Parts 3 and 4 during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the state population and the California Consumer Price Index.

(b) The department's review and approval of the programs specified in paragraphs (1) and (4) shall be limited to ensuring the consistency of such programs with the other portions of the plan and providing review and comment to the Mental Health Services Oversight and Accountability Commission.

(c) The programs established pursuant to paragraphs (2) and (3) of subdivision (a) shall include services to address the needs of transition age youth ages 16 to 25.

(d) Each year the Department of Mental Health shall inform counties of the amounts of funds available for services to children pursuant to Part 4 and to adults and seniors pursuant to Part 3. Each county mental health program shall prepare expenditure plans pursuant to Parts 3 and 4 and updates to the plans developed pursuant to this Section. Each expenditure update shall indicate the number of children, adults and seniors to be served pursuant to Parts 3 and 4 and the cost per person. The expenditure update shall include utilization of unspent funds allocated in the previous year and the proposed expenditure for the same purpose.

(e) The department shall evaluate each proposed expenditure plan and determine the extent to which each county has the capacity to serve the proposed number of children, adults and seniors pursuant to Parts 3 and 4; the extent to which there is an unmet need to serve that number of children, adults and seniors; and determine the amount of available funds; and provide each county with an allocation from the funds available. The department shall give greater weight for a county or a population which has been significantly underserved for several years.

(f) A county mental health program shall include an allocation of funds from a reserve established pursuant to paragraph (6) of subdivision (a) for services pursuant to paragraphs (2) and (3) of subdivision (a) in years in which the allocation of funds for services pursuant to subdivision (c) are not adequate to continue to serve the same number of individuals as the county had been serving in the previous fiscal year.

5848. (a) Each plan and update shall be developed with local stakeholders including adults and seniors with severe mental illness, families of children, adults and seniors with severe mental illness, providers of services, law enforcement agencies, education, social services agencies and other important interests. A draft plan and update shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy of such plans.

(b) The mental health board established pursuant to Section 5604 shall conduct a public hearing on the draft plan and annual updates at the close of the 30-day comment period required by subsection (a). Each adopted plan and update shall include any substantive written recommendations for revisions. The adopted plan or update shall summarize and analyze the recommended revisions. The mental health board shall review the adopted plan or update and make recommendations to the county mental health department for revisions.

(c) The department shall establish requirements for the content of the plans. The plans shall include reports on the achievement of performance outcomes for services pursuant to Parts 3, 3.6 and 4 funded by the Mental Health Services Fund and established by the department.

(d) Mental health services provided pursuant to Parts 3 and 4 shall be included in the review of program performance by the California Mental Health Planning Council required by Section 5772(c)(2) and in the local mental health board's review and comment on the performance outcome data required by Section 5604.2(a)(7).

Section 11. Section 5771.1 is added to the Welfare and Institutions Code to read:

5771.1 The members of the Mental Health Services Oversight and Accountability Commission established pursuant to Section 5845 are members of the California Mental Health Planning Council. They serve in an ex officio capacity when the Council is performing its statutory duties pursuant to Section 5772. Such membership shall not affect the composition requirements for the Council specified in Section 5771.

SECTION 12. Section 17043 is added to the Revenue and Taxation Code to read:

17043. (a) For each taxable year beginning on or after January 1, 2005, in addition to any other taxes imposed by this part, an additional tax shall be imposed at the rate of 1% on that portion of a taxpayer's taxable income in excess of one million dollars ($1,000,000).

(b) For purposes of applying Part 10.2 (commencing with Section 18401), the tax imposed under this section shall be treated as if imposed under Section 17041.

(c) The following shall not apply to the tax imposed by this section:

(1) The provisions of Section 17039, relating to the allowance of credits.

(2) The provisions of Section 17041, relating to filing status and recomputation of the income tax brackets.

(3) The provisions of Section 17045, relating to joint returns.

SECTION 13. Section 19602 of the Revenue and Taxation Code is amended to read:

19602. Except for amounts collected or accrued under Sections 17935, 17941, 17948, 19532, and 19561, and revenues deposited pursuant to Section 19602.5, all moneys and remittances received by the Franchise Tax Board as amounts imposed under Part 10 (commencing with Section 17001), and related penalties, additions to tax, and interest imposed under this part, shall be deposited, after clearance of remittances, in the State Treasury and credited to the Personal Income Tax Fund.

SECTION 14. Section 19602.5 is added to the Revenue and Taxation Code to read:

19602.5 (a) There is in the State Treasury the Mental Health Services Fund (MHS Fund). The estimated revenue from the additional tax imposed under Section 17043 for the applicable fiscal year, as determined under subparagraph (B) of paragraph (3) of subdivision (c), shall be deposited to the MHS Fund on a monthly basis, subject to an annual adjustment as described in this section.

(b) (1) Beginning with fiscal year 2004-2005 and for each fiscal year thereafter, the Controller shall deposit on a monthly basis in the MHS Fund an amount equal to the applicable percentage of net personal income tax receipts as defined in paragraph (4).

(2) (A) Except as provided in subparagraph (B), the applicable percentage referred to in paragraph (1) shall be 1.76 percent.

(B) For fiscal year 2004-2005, the applicable percentage shall be 0.70 percent.

(3) Beginning with fiscal year 2006-2007, monthly deposits to the MHS Fund pursuant to this subdivision are subject to suspension pursuant to subdivision (f).

(4) For purposes of this subdivision, "net personal income tax receipts" refers to amounts received by the Franchise Tax Board and the Employment Development Department under the Personal Income Tax Law, as reported by the Franchise Tax Board to the Department of Finance pursuant to law, regulation, procedure, and practice (commonly referred to as the "102 Report") in effect on the effective date of the Act establishing this section.

(c) No later than March 1, 2006, and each March 1st thereafter, the Department of Finance, in consultation with the Franchise Tax Board, shall determine the annual adjustment amount for the following fiscal year.

(1) The "annual adjustment amount" for any fiscal year shall be an amount equal to the amount determined by subtracting the "revenue adjustment amount" for the applicable revenue adjustment fiscal year, as determined by the Franchise Tax Board under paragraph (3), from the "tax liability adjustment amount" for applicable tax liability adjustment tax year, as determined by the Franchise Tax Board under paragraph (2).

(2) (A) (i) The "tax liability adjustment amount" for a tax year is equal to the amount determined by subtracting the estimated tax liability increase from the additional tax imposed under Section 17043 for the applicable year under subparagraph (B) from the amount of the actual tax liability increase from the additional tax imposed under Section 17043 for the applicable tax year, based on the returns filed for that tax year.

(ii) For purposes of the determinations required under this paragraph, actual tax liability increase from the additional tax means the increase in tax liability resulting from the tax of 1% imposed under Section 17043, as reflected on the original returns filed by October 15th of the year after the close of the applicable tax year.

(iii) The applicable tax year referred to in this paragraph means the 12-calendar month taxable year beginning on January 1st of the year that is two (2) years before the beginning of the fiscal year for which an annual adjustment amount is calculated.

(B) (i) The estimated tax liability increase from the additional tax for the following tax years is:

Tax Year	Estimated Tax Liability Increase from the Additional Tax
2005	$ 634 million
2006	$ 672 million
2007	$ 713 million
2008	$ 758 million

(ii) The "estimated tax liability increase from the additional tax" for the tax year beginning in 2009 and each tax year thereafter shall be determined by applying an annual growth rate of seven (7) percent to the "estimated tax liability increase from additional tax" of the immediately preceding tax year.

(3) (A) The "revenue adjustment amount" is equal to the amount determined by subtracting the "estimated revenue from the additional tax" for the applicable fiscal year, as determined under subparagraph (B), from the actual amount transferred for the applicable fiscal year.

(B) (i) The "estimated revenue from the additional tax" for the following applicable fiscal years is:

Applicable Fiscal Year	Estimated Revenue From Additional Tax
2004-05	$ 254 million
2005-06	$ 683 million
2006-07	$ 690 million
2007-08	$ 733 million

(ii) The "estimated revenue from the additional tax" for applicable fiscal year 2007-08 and each applicable fiscal year thereafter shall

be determined by applying an annual growth rate of 7 percent to the "estimated revenue from the additional tax" of the immediately preceding applicable fiscal year.

(iii) The applicable fiscal year referred to in this paragraph means the fiscal year that is two (2) years before the fiscal year for which an annual adjustment amount is calculated.

(d) The Department of Finance shall notify the Legislature and the Controller of the results of the determinations required under subdivision (c) no later than ten (10) business days after the determinations are final.

(e) If the annual adjustment amount for a fiscal year is a positive number, the Controller shall transfer that amount from the General Fund to the MHS Fund on July 1 of that fiscal year.

(f) If the annual adjustment amount for a fiscal year is a negative number, the Controller shall suspend monthly transfers to the MHS Fund for that fiscal year, as otherwise required by paragraph (1) of subdivision (b), until the total amount of suspended deposits for that fiscal year equals the amount of the negative annual adjustment amount for that fiscal year.

SECTION 15. Part 4.5 (commencing with Section 5890) is added to Division 5 of the Welfare and Institutions Code, to read:

PART 4.5. MENTAL HEALTH SERVICES FUND

5890. (a) The Mental Health Services Fund is hereby created in the State Treasury. The Fund shall be administered by the department of Mental Health. Notwithstanding Section 13340 of the Government Code, all monies in the Fund are continuously appropriated to the Department, without regard to fiscal years, for the purpose of funding the following programs and other related activities as designated by other provisions of this Division:

(1) Part 3 commencing with Section 5800, the Adult and Older Adult System of Care Act.

(2) Part 3.6 commencing with Section 5840, Prevention and Early Intervention Programs.

(3) Part 4 commencing with Section 5850, the Children's Mental Health Services Act.

(b) Nothing in the establishment of this Fund, nor any other provisions of the Act establishing it or the programs funded shall be construed to modify the obligation of health care service plans and disability insurance policies to provide coverage for mental health services, including those services required under Section 1374.72 of the Health and Safety Code and Section 10144.5 of the Insurance Code, related to mental health parity. Nothing in this Act shall be construed to modify the oversight duties of the Department of Managed Health Care or the duties of the Department of Insurance with respect to enforcing such obligations of plans and insurance policies.

(c) Nothing in this Act shall be construed to modify or reduce the existing authority or responsibility of the Department of Mental Health.

(d) The Department of Health Services, in consultation with the Department of Mental Health, shall seek approval of all applicable federal Medicaid approvals to maximize the availability of federal funds and eligibility of participating children, adults and seniors for medically necessary care.

(e) Share of costs for services pursuant to Parts 3 and 4 shall be determined in accordance with the Uniform Method for Determining Ability to Pay applicable to other publicly funded mental health services, unless such Uniform Method is replaced by another method of determining co-payments, in which case the new method applicable to other mental health services shall be applicable to services pursuant to Parts 3 and 4.

5891. The funding established pursuant to this Act shall be utilized to expand mental health services. These funds shall not be used to supplant existing state or county funds utilized to provide mental health services. The state shall continue to provide financial support for mental health programs with not less than the same entitlements, amounts of allocations from the General Fund and formula distributions of dedicated funds as provided in the last fiscal year which ended prior to the effective date of this Act. The state shall not make any change to the structure of financing mental health services, which increases a county's share of costs or financial risk for mental health services unless the state includes adequate funding to fully compensate for such increased costs or financial risk. These funds shall only be used to pay for the programs authorized in Section 5892. These funds may not be used to pay for any other program. These funds may not be loaned to the state General Fund or any other fund of the state, or a county general fund or any other county fund for any purpose other than those authorized by Section 5892.

5892. (a) In order to promote efficient implementation of this Act allocate the following portions of funds available in the Mental Health Services Fund in 2005-06 and each year thereafter:

(1) In 2005-06, 2006-07, and in 2007-08 10% shall be placed in a trust fund to be expended for education and training programs pursuant to Part 3.1.

(2) In 2005-06, 2006-07 and in 2007-08 10% for capital facilities and technological needs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association to implement plans developed pursuant to Section 5847.

(3) 20% for Prevention and Early Intervention Programs distributed to counties in accordance with a formula developed in consultation with the California Mental Health Directors Association pursuant to Part 3.6. Each county's allocation of funds shall be distributed only after its annual program for expenditure of such funds has been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

(4) The allocation for Prevention and Early Intervention may be increased in any county which the department determines that such increase will decrease the need and cost for additional services to severely mentally ill persons in that county by an amount at least commensurate with the proposed increase. The statewide allocation for Prevention and Early Intervention may be increased whenever the Oversight and Accountability Commission determines that all counties are receiving all necessary funds for services to severely mentally ill persons and have established prudent reserves and there are additional revenues available in the Fund.

(5) The balance of funds shall be distributed to county mental health programs for services to persons with severe mental illnesses pursuant to Part 4 for the Children's System of Care and Part 3, for the Adult and Older Adult System of Care.

(6) 5% percent of the total funding for each county mental health program for Parts 3, 3.6 and 4 shall be utilized for Innovative Programs pursuant to an approved plan required by Section 5830 and such funds may be distributed by the department only after such programs have been approved by the Oversight and Accountability Commission established pursuant to Section 5845.

(b) In any year after 2007-08, programs for services pursuant to Parts 3 and 4 may include funds for technological needs and capital facilities, human resource needs, and a prudent reserve to ensure services do not have to be significantly reduced in years in which revenues are below the average of previous years. The total allocation for purposes authorized by this subdivision shall not exceed 20% of the average amount of funds allocated to that county for the previous five years pursuant to this Section.

(c) The allocations pursuant to subdivisions (a) and (b) shall include funding for annual planning costs pursuant to Section 5848. The total of such costs shall not exceed 5% of the total of annual revenues received for the Fund. The planning costs shall include funds for county mental health programs to pay for the costs of consumers, family members and other stakeholders to participate in the planning process and for the planning and implementation required for private provider contracts to be significantly expanded to provide additional services pursuant to Parts 3 and 4.

(d) Prior to making the allocations pursuant to subdivisions (a), (b) and (c), the department shall also provide funds for the costs for itself, the Mental Health Planning Council and the Oversight and Accountability Commission to implement all duties pursuant to the programs set forth in this section. Such costs shall not exceed 5% of the total of annual revenues received for the Fund. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures set forth in Parts 3, 3.6 and 4.

(e) In 2004-05 funds shall be allocated as follows:
(1) 45% for Education and Training pursuant to Part 3.1.
(2) 45% for Capital Facilities and Technology Needs in the manner specified by paragraph (2) of subdivision (a).
(3) 5% for Local Planning in the manner specified in Subdivision (c) and
(4) 5% for State Implementation in the manner specified in subdivision (d)

(f) Each county shall place all funds received from the state Mental Health Services Fund in a local Mental Health Services Fund. The Local Mental Health Services Fund balance shall be invested consistent with other county funds and the interest earned on such investments shall be transferred into the Fund. The earnings on investment of these funds shall be available for distribution from the Fund in future years.

(g) All expenditures for county mental health programs shall be consistent with a currently approved plan or update pursuant to Section 5847.

(h) Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the Fund and available for other counties in future years, provided however, that funds for

capital facilities, technological needs or education and training may be retained for up to ten years before reverting to the Fund.

(i) If there are still additional revenues available in the fund after the Oversight and Accountability Commission has determined there are prudent reserves and no unmet needs for any of the programs funded pursuant to this Section, including all purposes of the Prevention and Early Intervention Program, the Commission shall develop a plan for expenditures of such revenues to further the purposes of this Act and the Legislature may appropriate such funds for any purpose consistent with the Commission's adopted plan which furthers the purposes of this act.

5893. (a) In any year in which the funds available exceed the amount allocated to counties, such funds shall be carried forward to the next fiscal year to be available for distribution to counties in accordance with Section 5892 in that fiscal year.

(b) All funds deposited into the Mental Health Services Fund shall be invested in the same manner in which other state funds are invested. The Fund shall be increased by its share of the amount earned on investments.

5894. In the event that Parts 3 or 4 are restructured by legislation signed into law before the adoption of this measure, the funding provided by this measure shall be distributed in accordance with such legislation; provided, however that nothing herein shall be construed to reduce the categories of persons entitled to receive services.

5895. In the event any provisions of Part 3 or Part 4 of this Division are repealed or modified so the purposes of this Act cannot be accomplished, the funds in the Mental Health Services Fund shall be administered in accordance with those sections as they read on January 1, 2004.

5897. (a) Notwithstanding any other provision of state law, the Department of Mental Health shall implement the mental health services provided by Parts 3, 3.6 and 4 of this Division through contracts with county mental health programs or counties acting jointly. A contract may be exclusive and may be awarded on a geographic basis. As used herein a county mental health program includes a city receiving funds pursuant to Section 5701.5

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of such mental health services. The agreement may encompass all or any part of the mental health services provided pursuant to these parts. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall implement the provisions of Parts 3, 3.2, 3.6 and 4 of this Division through the annual county mental health services performance contract, as specified in Part 2, Chapter 2, Section 5650 et seq.

(d) When a county mental health program is not in compliance with its performance contract, the department may request a plan of correction with a specific time-line to achieve improvements.

(e) Contracts awarded by the Department of Mental Health, the California Mental Health Planning Council, and the Mental Health Services Oversight and Accountability Commission pursuant to Parts 3, 3.1, 3.2, 3.6, 3.7, 4, and 4.5 may be awarded in the same manner in which contracts are awarded pursuant to Section 5814 and the provisions of subdivisions (g) and (h) of Section 5814 shall apply to such contracts.

(f) For purposes of Section 5775, the allocation of funds pursuant to Section 5892 which are used to provide services to Medi-Cal beneficiaries shall be included in calculating anticipated county matching funds and the transfer to the department

of the anticipated county matching funds needed for community mental health programs.

5898. The department shall develop regulations, as necessary, for the department or designated local agencies to implement this Act. In 2005, the director may adopt all regulations pursuant to this Act as emergency regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 2 of Title 2. For the purpose of the Administrative Procedure Act, the adoption of regulations, in 2005, shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. These regulations shall not be subject to the review and approval of the Office of Administrative Law and shall not be subject to automatic repeal until final regulations take effect. Emergency regulations adopted in accordance with this provision shall not remain in effect for more than a year. The final regulations shall become effective upon filing with the Secretary of State. Regulations adopted pursuant to this section shall be developed with the maximum feasible opportunity for public participation and comments.

SECTION 16

The provisions of this Act shall become effective January 1 of the year following passage of the Act, and its provisions shall be applied prospectively.

The provisions of this Act are written with the expectation that it will be enacted in November of 2004. In the event that it is approved by the voters at an election other than one which occurs during the 2004-05 fiscal year, the provisions of this act which refer to fiscal year 2005-06 shall be deemed to refer to the first fiscal year which begins after the effective date of this Act and the provisions of this Act which refer to other fiscal years shall refer to the year that is the same number of years after the first fiscal year as that year is in relationship to 2005-06.

SECTION 17

Notwithstanding any other provision of law to the contrary, the department shall begin implementing the provisions of this Act immediately upon its effective date and shall have the authority to immediately make any necessary expenditures and to hire staff for that purpose.

SECTION 18

This Act shall be broadly construed to accomplish its purposes. All of the provisions of this Act may be amended by a 2/3 vote of the Legislature so long as such amendments are consistent with and further the intent of this Act. The Legislature may by majority vote add provisions to clarify procedures and terms including the procedures for the collection of the tax surcharge imposed by Section 16.

SECTION 19

If any provision of this Act is held to be unconstitutional or invalid for any reason, such unconstitutionality or invalidity shall not affect the validity of any other provision.

City Hall
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689

City and County of San Francisco

Tails

Resolution

File Number: 031586 **Date Passed:**

Resolution urging the voters of the State of California to pass the Mental Health Services Act.

September 23, 2003 Board of Supervisors — ADOPTED

Ayes: 11 - Ammiano, Daly, Dufty, Gonzalez, Hall, Ma, Maxwell, McGoldrick, Newsom, Peskin, Sandoval

File No. 031586

I hereby certify that the foregoing Resolution was ADOPTED on September 23, 2003 by the Board of Supervisors of the City and County of San Francisco.

Gloria L. Young
Clerk of the Board

OCT 03 2003

Date Approved

Mayor Willie L. Brown Jr.

FILE NO. 031586 RESOLUTION NO. 638-03

[Urging California Voters to pass the Mental Health Services Act]

Resolution urging the voters of the State of California to pass the Mental Health Services Act.

WHEREAS, Mental illnesses are extremely common, affecting almost every family in San Francisco and people from every age group and background; and

WHEREAS, Failure to provide timely treatment can destroy individuals and families; and

WHEREAS, Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local governments; and

WHEREAS, An estimated 8,500 to 15,000 people in san Francisco are homeless or on the edge of homelessness and approximately 30% of the homeless population has a disabling mental illness; and

WHEREAS, San Francisco with the highest rate of homelessness in the United States, is also likely the United States city with the highest ratio of individuals who are homeless and suffering from disabling mental illness; and

WHEREAS, In a cost cutting move thirty years ago, California drastically cut back its services in state hospitals for people with severe mental illness; and,

WHEREAS, The Board of Supervisors of the City and County of San Francisco believe that California residents with mental illness deserve better service and support; and

WHEREAS, With effective treatment and support, recovery from mental illness is feasible for most individuals; and

WHEREAS, By expanding programs that have demonstrated their effectiveness California can save lives and money; now, therefore, be it

RESOLVED, That the Board of Supervisors of the City and County of San Francisco urges the voters of the State of California to pass the Mental Health Services Act, and enable California to lead the country in providing mental health services to persons currently disabled by mental illness, to persons showing signs of mental illness, and to families and caregivers of those affected.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.sfgov.org/mental_health

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UNADOPTED MINUTES
Mental Health Board
Wednesday, November 12, 2003
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Bob Douglas; Carol Knight; Andrea Leung, L.C.S.W., A.C.S.W.; Joel A. Luebkeman; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Kate Walker; Idell Wilson; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ON LEAVE: Augusta Del Zotto, Ph.D.; Supervisor Bevan Dufty; chance martin.

BOARD MEMBERS ABSENT: none.

PRESENTERS: Nick Hancock, Data Analyst, Community Behavioral Health Services

OTHERS PRESENT: Bob Cabaj, M.D. (Director, Community Behavioral Health Services); Edward Evans (Chair, Mayor's Disability Council); Jack Fagan (Mayor's Disability Council); Mary Crispi (Consumer); Delphine Brody (Healthy Access to Real Treatment); LaVaughn King, David Kan (UCSF; Behavioral Health Court); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator).

1.0 CALL TO ORDER AND CONSENT CALENDAR
The meeting was called to order at 6:40 p.m. by Ted Stinson, Chair.

Mr. Stinson: I want to start by giving our condolences to Kate who lost her sister recently.

We'll be having our Annual Retreat on Saturday, December 6th. This is one of the highlights of the year. It's a chance to reflect on our accomplishments of the past year, and to think strategically about what we want to do in the coming year. We also try to have some fun, too, and we have a meal together. This is really is an awfully important day.

I want to acknowledge two of our guests this evening: Edward Evans, Chair of the Mayors Disability Council and Jack Fagan, a member of the Mayors Disability Council

1.2.a RESOLUTION (MHB-2003-24): **Be it resolved that the minutes of the Mental Health Board meeting of October 8, 2003, be approved as submitted. (Passed unanimously.)**

1.2.b RESOLUTION (MHB-2003-25): **Be it resolved that the Mental Health Board grants leaves of absence for the meeting of November 12, 2003, to the following members: Augusta Del Zotto and chance martin. (Passed unanimously.)**

2.0 PRESENTATION AND DISCUSSION: AB1421 AND BEHAVIORAL HEALTH COURT

Mr. Stinson: This evening we decided to have a different format than usual. Typically we have someone come and speak to us about a topic of interest to the Board. In talking with the Board members and the Executive Committee members, it was clear to me that there is a desire to listen to ourselves as well. And in particular, there are two issues we have discussed in the past, and it's fair to say, that we have wrestled with, AB 1421, also known as Laura's Law, and Behavioral Health Court.

We'll have two speakers pro and con on AB 1421. And then the full Board will discuss both of these topics.

Let me begin with this background on AB 1421:

> Assembly Bill 1421 was introduced by California Assemblywoman Helen Thomson in February 2001 and was signed into law by Governor Davis in September 2002. This law establishes the Assisted Outpatient Treatment (AOT) Demonstration Act, a program which permits counties to mandate outpatient treatment for individuals whose mental illness has caused multiple hospitalizations or incarcerations and who have not linked, or refuse to link, with mental health services. The provisions of the bill became law on January 1, 2003, and are set to sunset on January 1, 2008.

Next I'd like to ask Dr. Cabaj about the status of AB 1421 in San Francisco.

Dr. Cabaj: It's nowhere right now. It can only be implemented at the order of the Board of Supervisors. It has been on their calendar for possible review, but it has not been scheduled yet.

Mr. Stinson: Now I'd like to ask Nick Hancock, Data Analyst for Community Behavioral Health Services to give us background on the bill as a point of departure for discussion.

Mr. Hancock: There is no funding from the State in this legislation, so there is a key question about where the funding is going to come from to implement the program.

What we did in analyzing this bill, was to start by trying to identify a likely level of service clients would be using under Assisted Outpatient Treatment. The closest program we have to AOT is intensive case management.

We looked at the administrative costs, direct service costs, and housing costs. The administrative costs resemble those for Proposition 36.

AB 1421 requires an intense level of direct services. Intensive case managers serve people at the same level that is required by AB 1421. So we thought that population would be a good model for making the estimate. We calculated costs based on 180 days of treatment, which is what people would be enrolled in.

We are estimating that per client for 180 days of treatment, the costs would be: Administration $436, Direct Services, $4,689, and Housing at $7,200, for a total of $12,329.

The big missing piece in our estimates is how many people would be ordered into treatment if the Board of Supervisors decided to enact AOT, because the client numbers would be driven by petition.

Kendras' Law in New York is a similar law. They were estimating 10,000 people statewide per year would be in the program. In practice, it turned out to be 1,000 people statewide in a year.

Mr. Luebkeman: Have any other counties implemented this program?

Dr. Cabaj: Los Angeles County is about to launch it in a unique way with people who are incompetent to stand trial. They are in the court system already. They are already in an involuntary situation. No other county is implementing AB 1421. They are still waiting. It's expected that there will be a lot of legal challenges.

Mr. Douglas: Do you have any idea what the legal costs would be for the program?

Mr. Hancock: Due process is built right into the AB 1421 system. There is the right of appeal at every step.

Dr. Cabaj: A very big hidden cost is the court-related cost. They are not DPH costs but City costs. There is the right of appeal and a court review every six months. Most counties have not had a way to analyze what that cost would be.

Mr. Stinson: Have we been able to look at the experience of New York and to understand what the total relevant cost is, specifically the upfront cost netted against the benefits of reduced hospitalization or incarceration?

Mr. Hancock: I wasn't tasked with investigating that. From looking on the internet there is no conclusive data so far. The Rand Institute is studying this.

Our five-year study of Single Point of Responsibility programs, which are intensive case management programs, showed a marked decrease of hospital days.

Dr. Cabaj: The cost of delivering that community-based service and the savings to the system have evened out. But AB 1421 is somewhat different because of the court costs.

Mr. Douglas: Do you think some of the people who are in the system now are going to become involuntary?

Dr. Cabaj: Many of the people are in the system and may not stay. I think the Behavioral Health Court offers us just as much chance to make an intervention. AB 1421 does not allow the court to be brought in. If the person is in AB 1421 there is no leverage. It's an odd situation that was created.

Ms. Brown: From the statistics that Mr. Hancock gave, they are assuming that everyone is homeless. What about people who have housing, but get caught up in this program and become homeless?

Dr. Cabaj: I think they didn't have a clear idea of exactly who would be using this program. Hopefully no one would lose housing in this program. It would just be that housing would be provided for people who didn't have it.

Dr. Moses: This Board is divided on AB 1421. Could you educate us about the pros and cons? Second, about the budget figure of $12,000, are we being realistic about that? Could direct services be more than housing? I'd like them to look into that. The direct services are very important to our clients.

Dr. Cabaj: The Department wanted to focus on the average client. This is very hard to predict. My bet is that the $12,000 per client figure is quite under what the actual cost will be.

Mr. Hancock: In terms of feasibility, there is no state money in the legislation, and counties can't take money from existing services to set up AB 1421 programs. It has to be new money, and I don't know where that would come from.

Mr. Stinson: Now Kate and I are going to make presentations on AB 1421. Kate and I have spoken pro and con on this issue of involuntary outpatient treatment in the past. We will give you a fairly unambiguous pro and con. I'll be starting first with the pro position.

There's a group of individuals in our community who by virtue of the disease lack the ability to make decisions for themselves. I'm speaking based on my reading, but also from the very personal experience of having lived with someone with severe schizophrenia. We're not talking about all people with mental illness, but rather a very, very, very small group of individuals. The result of the way things work now is they are not getting treatment or they are going through the revolving door of treatment.

There is some research, but it is preliminary in nature and not conclusive.
The Rand Institute studied several thousand people in this category in California.

There are two questions in my mind: 1) Can involuntary outpatient treatment be effective? Can this help individuals out? There was an editorial in the Los Angeles Times by the people who did this study. They determined that involuntary treatment when done in context of services and housing can be effective.

2) Who do we as a society prioritize for treatment? Do we prioritize those who demand it, and do we in the process de-prioritize those who cannot request or demand it, or don't know they need it?

I reject the argument that voluntary treatment is more important. I think we have to take into account the people who can't ask for services.

With regard to civil liberties, there is a fairly onerous list of steps. As much as possible this is an unbiased process, in that a judge decides about the claims. We can always talk about civil liberties, and that is a corner stone of our society and a question that needs to be asked. But this legislation has taken civil liberties into account as best as possible.

I want to highlight a few of the eligibility criteria:

The person must have had a history of non-compliance with treatment, that has either: a) Been a significant factor in his or her being in a hospital, prison or jail at least twice within the last thirty-six months; or b) Resulted in one or more acts, attempts or threats of serious violent behavior toward self or others within the last forty-eight months. So there has to be a history.

The person must have been offered an opportunity to engage in voluntary services. If they sought services and are engaged, they are not eligible.

In view of their treatment history and current behavior, are they in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would like result in the person meeting California's inpatient commitment standard, specifically being a serious risk of harm to self or others, or gravely disabled.

Ms. Walker speaking in opposition to AB 1421: Ted you said that wanting to take the medications didn't take priority, that we shouldn't give treatment to people who want it exclusively, that people who need it and don't ask for it should be given consideration, too. I refer you to the law.

Laura, for whom the law was titled, was a worker somewhere in California. A client came into their office and demanded treatment and the office didn't provide it. The guy who killed Laura, killed her because he was seeking treatment that they didn't give him.

There are many who say that the treatments that are offered don't work. There are many people who are being asked to take treatment and wish to refuse it. For example, a woman who found herself in a psychiatric hospital said, "I'm going to get out of here and get my GED and then I'm going to college and then to medical school." She looked at the notes. The notes said she was acting up. She ended up getting her doctor's degree.

A lot of people know themselves and know what's best for themselves. The treatment can be very harsh. Look at all the day care centers that have a time for medication. That may seem pretty silly, but you look at the pills one has to take, a bag of them. These pills are for what's assumed to be wrong with them, the side effects are obvious, and then there are pills to counteract the side effects. It isn't an exact science.

Is this 1421 a medical procedure or is it a legal procedure? If it's a legal procedure, what information does the judge have to decide whether the person should take the

treatment if the person doesn't want treatment? This seems very chaotic to me; it doesn't seem scientific. How can that judge say you have to take treatment even if you don't want it?

As to Laura's Law, as I understand it Helen Thomson wanted that law so badly that she would accept any amendments at all to get it through. One of the ways to weaken the law was to make the definitions so vague that they could be legally challenged.

One of the definitions is gravely disabled. Who says you're gravely disabled? Who says you're in need? Paragraph by paragraph there are vague definitions. And Protection and Advocacy, the law office for people with mental health problems, is sitting there and ready to take action.

You can't take money from any program that's existing. This last budget has cut program after program. There isn't going to be any money for it.

It was said, in the context of putting people in the program, that you don't want to use the word hook, because it doesn't sound right, but that's what you're doing, you're hooking them. As Judge Breall said in a meeting here, coercion doesn't work, if I remember correctly. And this is a coercive program.

Mr. Douglas: If we can give people inpatient treatment under 5150 it doesn't make sense to give them outpatient treatment which is a lot less restrictive than inpatient. In my prior career I was a case worker and social worker, and what worries me about this law, is that these people who are making the decisions are not God. When you bring someone one into their office who doesn't want to be there, they don't have a magic wand they can wave. We're talking about spending money we don't have on a group extremely difficult to change. I think there is a lot of overlap with the population we have now and these people AB 1421 is talking about.

Ms. Knight: I'm concerned about the cost. After the first 180 days are up, what happens to the client? Do they get another 180 days? My family member took a long time to become compliant. It could have cost a lot of money. This seems like a yo-yo, which is devastating for families. And the City doesn't have that kind of money.

Dr. Cabaj: I know you can petition at least one more cycle of 180 days. I don't know if it goes beyond that. For most people, they presume you'll be there a year, but you go through the whole process every 6 months.

Mr. Luebkeman: I think for all of us in this room, probably the reason why we are on this Board is that we had experience with mental illness ourselves or have family members who suffered from illness. We all have empathy for those who suffer. Like Ted, I have a close family member who suffered from schizophrenia. It was a horrible state of suffering that I saw my family member go through. I can't understand why you would let someone continue to writhe in that pain.

Severe mental illness is a horrible thing. I understand treatment doesn't work for everyone. But for those for whom it does work for it's wonderful. If it were cancer, we wouldn't be talking about what it costs.

Dr. Moses: This bill is missing the transition plan. There should be an aftercare plan. If not, the client is right back to the revolving door. After the 180 days, there should be a transition plan.

We are talking about money because we want the money to be well spent. So that people get really good care. We don't want this money to be spent on staff only or housing only. I'm glad to see us addressing this issue so we can put it to rest.

Ms. Walker: Whoever devised this meeting, cheers to them. I want to thank them.

Joel, you and Ted have spoken of family members. I'm one of the ones; I went crazy. Did the medications help? Well they certainly calmed me down. But what the medications did was to mask the symptoms, and the disease was untouched, if you call it a disease. You say that it's a crime to suffer. I took the medications and sat there calmly and you wouldn't know that I was suffering, but I suffered. I hadn't the use of my mind. I looked better; I felt worse.

Somebody who is suffering can get angrier, show emotion. In the psychiatric hospital, I believe that's called acting out, so we need medications to calm them down, and you think they are fine, but they may be feeling much worse. The worst thing about it is that you can't use your mind. You can't have an original thought. You become like a vegetable inside, and you don't want to be a vegetable.

Ms. Shaffer: I'm kind of in a unique position. I'm a family member and a health care provider. It's nothing for a family to spend this kind of money for their loved one. The top line is prevention. Prevention is my golden rule in my work as a school nurse.

What I see is so many gaps in the system. Gaps in communication. By the time you could have done prevention or early intervention, things get worse. I respect what both of you are saying. But I think we have to look at the gaps in the system. I see gaps left and right. I know how hard I advocate for my family members and for my clients. I'm constantly amazed at how hard it can be to get things going and how long it can take to get treatment, even when someone is suicidal.

People are out there asking for help and they are not getting it. The voluntary services are not working well enough. I'm in a quandary about this bill, because it seems to me that prevention is the priority. It will cost a whole lot less than this.

Ms. Leung: I have to say both of you delivered very convincing speeches. But I think I have to disagree with Kate's opinion. I think when staff deliver that medication to you and force you to take medication, there is a lot of consideration that has taken place before that approach. There is a lot we have to consider before we use medications. I remember once there was a patient who was screaming her lungs out, and we asked the psychiatrist for medications. He said, "I guess you just want to have an easy shift." It's not that we don't want to hear the patient scream and yell. I don't think the patient feels well.

If you are saying after the medications, you feel worse, the statistics show that a lot of people when they get out of the acute episode of schizophrenia, do experience a period of depression.

I validate your experience and your point, but at the same time as a service provider who has seen a lot of revolving door patients, if all the criteria are being enforced, then I believe this is certainly a good law.

Mr. Luebkeman: Kate, I very much respect where you're coming from. You spoke about not having the use of your mind. I don't know your particular situation. With my family member, I saw the loss of a bright, happy person to someone who became a very different person. When she started taking medication, she became more who she was and was able to hold a job. It was as if the treatment opened the door of a prison and let her out rather than imprisoning her.

I very much agree with Dorothy. Prevention is so important.

Ms. Walker: Joel, your point is right on. People are different. In the survivor community we believe if you want to take medications, take them. But some of the medications are a mental strait jacket.

Mr. Stinson: I want to ask Dr. Cabaj for his comments before he leaves.

Dr. Cabaj: This is a very helpful discussion. I've learned a lot already. I know this law's been pending for quite a while. State directors of mental health programs have been looking at this for over a year.

The law itself is quite flawed. We know that the studies show that care works best when it's voluntary. We're doing a research study to ask clients to see if they feel coerced or free in their current treatment even without AB 1421.

Behavioral Health Court might be another way of providing treatment to people who are not fully aware of how they need treatment.

I originally thought the concept of AB 1421 was okay if we can find a tool for that very small group who continue to hurt themselves or others.

But this law is flawed. It's not just cost alone. It's also the infringement of rights. I get nervous about this concept of who can decide who gets treatment. The legal checks are there to help counter that, but it adds layers of distress. DPH took a stand in supporting the law before it was passed. But since it's been passed, DPH has been silent.

Personally, I hope we don't take the course of AB 1421 because of all the complications we've mentioned. But if the Board of Supervisors decides to go forward with this, then we'll engage with that.

We're watching what happens in Los Angeles County as they implement their approach to AB 1421. Other counties are waiting to see what happens and to watch the court challenges. I'd say let's wait and see.

I know Helen Thomson felt the law had to be passed, and she did accept amendments that she didn't really want. And so the law is kind of gerrymandered.

Mr. Luebkeman: What are examples of the flaws?

Dr. Cabaj: The biggest flaw is the inability to have intervention. There are no legal consequences. The County can demand treatment, but cannot enforce it. There are not really any additional interventions. You could revert to the 5150, but the client would have to meet those requirements.

The law got written without the cost factor. Not funding this law was the biggest attempt by some politicians to make sure that the law could not be used.

Helen Thomson is now a member of the Board of Supervisors of her county and can't get the law passed through her own county.

Dr. Moses: What about after 180 days are up?

Dr. Cabaj: We want to engage people, and find ways, like Joel and Kate are saying, to reduce suffering. We want to find ways of treatment that are not a matter of the expert telling people what to do, but engaging people in the recovery model, and helping them to understand what they are engaged in.

For many clients after the 180 days or one year, they'll be right back where they started.

Another piece of legislation, AB 1424, is a slight change in LPS law. It allows the judge to use the client's history in making a 5150 determination. I hope this new variation will allow judges to make better decisions and help us engage people better.

DIRECTORS REPORT *(taken out of order)*
Dr. Cabaj: With regard to the State budget, everything is on hold until the new governor is sworn in. We don't know if Dr. Mayberg will stay on as State Director of Mental Health. They may combine the State Department of Mental Health and the State Department of Alcohol and Drug Programs, which could be good from my point of view. There is a lot of concern about the Vehicle License Fee. Governor-elect Schwarzenegger has said he wants to cut it, but if no backfill funding to make up for that cut, the counties could really suffer.

There is no news on local budget, because we don't know who the mayor is going to be. We are hearing that so far the revenue numbers are not good. We hear that there have been extra costs in the hospitals and jails which could create a $20 million deficit in this fiscal year for whole Department of Public Health.

I know Gwen Tucker, Chief of Juvenile Probation, gave an interesting and stimulating report at your Board meeting last month. She and I and Barbara Garcia have had one meeting and we have another one scheduled for next month to address issues of caring for youth, and I think we are on a good track. Ms. Tucker raised the assessment issue. There has been a significant effort to streamline the assessment and intake process. I've

been pushing for this. We are down to a one-page assessment report instead of several pages, and an assessment several days at the most instead of several months. Gwen Tucker was very pleased to hear this.

With regard to the Youth Task Force, Victor Damian, who is a dynamo, has been telling us what we need to do differently in our work with youth and we're going to listen. We've invited them to participate with our Executive Team.

Mr. Douglas: Victor gave a very compelling presentation about using groups in treatment and I wondered if you were thinking about doing more of that.

Dr. Cabaj: Absolutely. I've been visiting all of our programs and I'm encouraging more use of groups both on the youth and adult level. One of the adult programs didn't believe in groups, but to their astonishment they worked and the clients really liked them.

Ms. Shaffer: Victor did give a dynamic presentation. It was quite inspiring. We talked about issues with the school district. I'm wondering how to help families. They have to keep advocating with the school district and it's a continuing challenge.

Dr. Cabaj: We should probably have a whole discussion on the 3632 program. San Francisco has been dedicated to it, even without state or federal reimbursement. What happens is many of the families want care, and sometimes the mental health clinician feels that more is not needed. Maybe there's a legislative way to address that problem.

Dr. Moses: Thank you for coming back to our meeting.

Dr. Cabaj distributed the written Director's Report:

Budget Update. There is no new information on the budget since the October, 2003 report.

New Forensic Linkage Program. The San Francisco Sheriff's Department has directed some of its Treatment-on-Demand grant funding for FY 2003-04 towards creating a new Citywide Forensic Linkage program to be run by UCSF. The Sheriff's Department identified a population in the County Jail that is dually diagnosed (substance abuse and mental illness) but behaviorally low-functioning and not appropriate for residential treatment programs or early release due to concerns of homelessness and inadequate support systems for these individuals. In order to facilitate the release of these individuals, provide monitoring for community safety, provide treatment linkage immediately, and reduce re-arrests, Citywide Forensic Linkage will provide time-limited transitional services and housing to these dually diagnosed individuals. The new program will link with clients prior to their release from jail, provide needed mental health and substance abuse services, obtain housing in SROs using weekly vouchers and provide linkage of clients to the appropriate level of care in the system. Two full-time case managers and a part-time time occupational therapist will staff this program, and approximately 150 clients would be served during a full year. This new program is scheduled to begin in November 2003.

National Juvenile Defenders Conference. Members from the CBHS/ CYF Youth Task Force were invited to present at the National Juvenile Defenders Conference in Baltimore, Maryland in October 2003. They shared their experience as consumers in the juvenile justice and other child serving systems. Their presentation received a standing ovation from the conference participants. One of the participants wrote the following thank you comment to the team: "I am an attorney in Baltimore City, Maryland and I attended the Juvenile Defenders Conference this past weekend. I cannot tell you how very much the presentation meant that you and your team put on at the conference. My heart was touched in ways that will have an everlasting impact on how I continue to represent young people." The CBHS/CYF Youth Task Force is a group of young people under the age of 18, who have been consumers in one of the child-serving systems (Behavioral Health, Juvenile Justice, Child Welfare, Special Education). They meet regularly and provide ongoing feedback to the various systems with regard to their experience as well as ways of improving services to young people. The Task Force is managed through a contract with Legal Services for Children, and is part of the Children's System of Care Initiative

CYF Uniform Wraparound Services Intake. In October, the Children's System of Care Program and the Family Mosaic Project unveiled a uniform wraparound services intake and referral process, which streamlined the referral form for wraparound service to one page, and for families to be contacted by a wraparound case manager within five working days. The procedure also set aside three wraparound slots per partner agency (Juvenile Justice, Child Welfare and School District) per month up to program capacity limits. This streamlined process of referral enables community agencies and departments alike to access wraparound services in the CYF section through a single process. Child welfare workers, mental health providers, substance abuse treatment providers, probation officers and teachers will gain quicker access to wraparound support services for children and youth with serious emotional disturbances who are under their care.

Mr. Stinson: Now we'll resume our discussion of AB 1421. Also, as you recall during the last Board meeting, we tabled a resolution supporting the Behavioral Health Court until this meeting, pending further information.

Dr. Turner: I have really enjoyed this discussion and have appreciated you getting us to talk further about it. I'm thinking how little difference there is between this bill and a 5150 hold. There is just a fine line between imminently dangerous and likely to be dangerous. But it is important to consider the issue of how legal righs are protected. I would like to hear more about why people think this bill is flawed. I find the Rand study very interesting, and it would be good to get more data from New York and Los Angeles. There is data out there, it just needs to be collected.

I've seen people suffer from getting treatment they didn't want. And I've seeen people suffer from not getting treatment they needed, and proabbaly more from the later.

Mr. Luebkeman: I would like us to take up the resolution on the Behavioral Health Court.

Ms. Brooke: I spoke with Chance Martin. He has requested the data on outcome measures and evalution criteria from the Behavioral Health Court, and they have not responded yet. It has been three weeks.

Ms. Walker: In Behavioral Health Court, as I understand it, one can choose to be in jail or in the BHC. You give up your right for a trial if you are in the BHC. You could actually stay in jail longer.

Mr. Douglas: As a lawyer, I've had experience representing people in Behavioral Health Court in San Jose, and I can say the defendents would much rather be in the program than not in the program. Most of them do not stay in jail. A court is not a democracy. When you are dealing with judges, you are dealing with people who can do anything from fine you to sentence you to death. They are not used to being evaluators, so I don't think we're going to get the same kind of data from the court that we'd get from a treatment program.

The judges are not social workers. One of them told me, "I get paid to make tough decisions." I strongly support the BHC, and I don't think we can expect the kind of data that we get from mental health programs.

Ms. Walker: The Mayor's Disability Council had a meeting, and two people from BHC were there. They said that in some circumstances you can be held in jail onger than if you're not in BHC.

Dr. Kan: I'm a forensic psychiatry fellow at UCSF, and an active participant in the Behavioral Health Court in San Francisco. I participate in meetings of the treatment teams. With regard AB 1421, it needs to be established if this is a criminal issue or civil issue. Criminals are given more protection. My reading of the bill is that this is going to catch a fairly select group. It's an adversarial process with guaranteed representation. It costs $26,000 a year to incarcerate someone in jail or prison.

Under AB 1421 doctors will make recommendations, but we are not the finders of fact. Judges will ultimately make the descisions. BHC is a pre-plea court, offered as diversion Medications are not coerced. You do not go into jail for not taking medications.

Ms. Crispi: I come from the perspective of a mental health person with dual disagnosis. I'm the cooperative one. I live in an SRO and we've got people there whom we have to evict. We have people who refuse to cooperate and cause problems for people there. And it's very expensive to evict people. The Shelter Plus Care people especially. This one woman was beyond help. She was in and out, and in and out. One thought is that AB 1421 should be implemented. I agree with most of it, but with reservations. Is there a uniform standard?

Mr. Fagan: I wanted to let everyone know that you are invited to the next meeeting of the Mayor's Disability Council, next Friday from 1:30 to 4:30. It will focus entirely on AB 1421. What I personally felt and I think fellow Coucil members felt, was the testimony at our last meeting was the worst case scenario about people's rights being abused versus the needs of very ill people. I'm interested more in the kinds of things you've talked

about tonight, and by the way, these are very nice materials. I'm concerned about Bridgett's point that if people are living on their own and they are in need of treatment, who's going to petition to get them into treatment?

Mr. Purvis: I'm a frustrated NAMI member who helped get this legislation passed. An earlier version had $500,000,000 of state funding included. My wife is in need of treatment, but this bill wouldn't apply to her, because she's not been hospitalized in the last three years. She refuses medication and treatment and she's homebound. I wish she would go out and get arrested. That's a terrible thing to say, but that would get her into the system. She needs intensive services. She didn't have symptoms until her mid 40s. She was very accomplished in her life. I had high hopes originally for the legislation. I guess I'm still looking for something that would help my situation.

Ms. Brody: I'm from HART, Healthy Access to Real Treatment, which is a coalition of mental health consumers and psychiatric providers who are opposed to AB 1421 throughout the state. I'm also in the Mental Health 101 project, as the oordianrtor and trainer. And I'm a mental health consumer. I'm strongly opposed to 1421 for a whole heost of reasons. And I ahve some serious concerns about BHC.

I'm opposed to AB 1421, first and foremost, because it threatens all our civil rights. The criteria are so broad and vague that anyone in this room could be forced into it. A couple of examples are "substantial deterioration," "non-compliance," "at high risk of poor outcome." These terms are unacceptably vague. If AB 1421 is implemented, it's going to be open season on all our civil rights.

3.2 Report from the Executive Director of the Mental Health Board
Ms. Brooke: The Mental Health Board will be holding its Annual Retreat on December 6th at the Hotel Nikko.

4.0 MENTAL HEALTH BOARD COMMITTEES

4.1 Report of the Chair of the Board and Executive Committee
Mr. Stinson: We have the Behavioral Health Court resolution on the agenda.

Ms. Walker: I move that we table the resolution on the BHC until the January meeting.

Mr. Luebkeman: This is the issue, that a commitment was made at the last meeting to address this resolution in this meeting. I think we should put it to a vote.

RESOLUTION: That the MHB table its resolution on the Behavioral Health Court until January 14, 2004. (Did not pass.)

In favor of the motion: Ms. Brown, Ms. Shaffer, Ms. Walker.
Opposed to the motion: Mr. Douglas, Ms. Knight, Ms. Leung, Mr. Luebkeman, Dr. Moses, Mr. Stinson, Ms. Turner, Ms. Yuen, Mr. Yun.

Public Comment on the Behavioral Health Court Resolution:

Ms. Brody: I have some questions about the BHC. Is this court truly voluntary? If this is not a pre-plea alternative to jail time, then what is it? Are the public defenders qualified to prescribe treatment or services? It remains to be seen what the penalties may be if someone doesn't comply, although it has been said they will be sent back to the court they come from. To me that seems very coercive. I think these questions deserve consideration before you vote.

Dr. Kan: Behavioral Health Court is a pre-plea court. The public defenders don't recommend treatment. They rely on the doctors and the case workers who are on the treatment team. If I had to chose between AB 1421 and BHC, I'd go with BHC. It's the best bet for getting people into treatment, but it also provides the opportunity that they don't have to have felonies on their records, which has lasting impact in terms of getting jobs. This is a huge issue for a lot of clients.

Mr. Fagan: The Mayor's Disability Council is drafting a resolution in support of BHC. And that will be voted on next week. We'd like to specifically schedule a member of the MHB to come and speak on our agenda to give us a summation.

Ms. Crispi: There is no time limit for BHC. It's different tracking behavior than tracking addictions. It seems a little vague to me, like with AB 1421, it doesn't seem clear and concise. Like you said, there is no time limit on BHC. I think there should be a time limit.

RESOLUTION (MHB-2003-26):
IN SUPPORT OF THE BEHAVIORAL HEALTH COURT

WHEREAS, far too many people with mental illness end up in the criminal justice system rather than in the mental health system, and

WHEREAS, these people with mental illness need treatment rather than punishment, and

WHEREAS, the newly-developed Behavioral Health Court is proving itself to be a very effective and humane way to help mentally ill offenders get into treatment, and

WHEREAS, the Behavioral Health Court involves a multidisciplinary team and is an excellent role model for the coordination and integration of services across City departments, and

WHEREAS, the Behavioral Health Court helps keep clients from falling into the cycle of recidivism, and

WHEREAS, the Mental Health Board has had two presentations on the Court, one by Judge Harold Kahn on January 8, 2003, the first day of operation for the Court and one on September 10, 2003, a nine-month follow up by Judge Susan Breall, now therefore,

BE IT RESOLVED, that the San Francisco Mental Health Board commends the City and County of San Francisco for creating and supporting the Behavioral Health Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board commends the Superior Court of the City and County of San Francisco, and especially Judges Kahn, Breall, and their colleagues for their strong commitment to the Court and their compassion for the clients of the Court, and

BE IT FURTHER RESOLVED, that the Mental Health Board urges the City and County of San Francisco to make it a priority to increase funding and support for the Court, so the Court can increase the number of clients it works with. (Passed.)

In favor of the resolution: Mr. Douglas, Ms. Knight, Ms. Leung, Mr. Luebkeman, Dr. Moses, Mr. Stinson, Ms. Turner, Ms. Yuen, Mr. Yun.
Opposed to the resolution: Ms. Brown, Ms. Shaffer, Ms. Walker, Ms. Wilson.

Mr. Douglas: With regard to the Mental Health Services Act, this is something that is new to me. People are going out and gathering signatures to put this on the ballot. I don't know why we need to vote on something that is going out for signatures for the ballot.

This seems to duplicate some of the existing system. It creates a council. How does that relate to the Mental Health Boards? I think we should table this. I think it takes a lot more discussion than we have time for tonight.

Seconded by Dr. Moses.

RESOLUTION (MHB-2003-26): That the MHB table its resolution on the Mental Health Services Act until January 14, 2004. (Passed.)

In favor of the resolution: Ms. Brown, Mr. Douglas, Ms. Knight, Ms. Leung, Dr. Moses, Ms. Shaffer, Mr. Stinson, Ms. Turner, Ms. Walker, Ms. Wilson, Ms. Yuen, Mr. Yun.
Opposed to the resolution: Mr. Luebkeman

5.0 NEW BUSINESS
Dr. Moses: I'd like us to invite Herbert Donaldson, the current judge of the Behavioral Health Court to do a presentation. (Or if there is a new judge in January, whoever is the new judge.) And I'd like us to invite Margaret Brodkin of Coleman Advocates.

Ms. Shaffer: I'd recommend having Victor Damian and the Youth Task Force for a full board meeting.

6.0 PUBLIC COMMENT
No additional public comment.

There being no further business, the meeting was adjourned at 8:32 p.m.

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: (415) 255-3760
mhb@igc.org
www.sfgov.org/mental_health

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The Mental Health Board meeting scheduled for December 10, 2003, has been CANCELED

The Board will be holding its Annual Retreat on Saturday, December 6, 2003, at the Hotel Nikko, 222 Mason Street from 9 a.m. to 4 p.m.

No final votes will be taken by the Board at the Retreat. Any proposals or resolutions developed by the Board during the Retreat will be placed on the agenda for public comment and to be voted on at its next regular meeting on **Wednesday, January 14, 2004**.

An agenda for that meeting will be sent out at the beginning of January.

Department of Public Health

SAN FRANCISCO MENTAL HEALTH BOARD

1380 Howard Street, Suite 510
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@igc.org
www.ci.sf.ca.us/mental_health

Minutes

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RETREAT NOTES
Mental Health Board
Saturday, December 6, 2002
1380 Howard Street, Room 537
San Francisco, CA 94103
6:30 p.m.

BOARD MEMBERS PRESENT: Ted Stinson (Chair); Bridgett Brown; Augusta Del Zotto, Ph.D.; Bob Douglas, J.D.; Supervisor Bevan Dufty; Carol Knight, M.A.; Andrea Leung, L.C.S.W., A.C.S.W.; Joel Luebkeman; Toye Moses, Ph.D., M.P.H.; Dorothy Shaffer, R.N., N.P., M.S.N.; Rebecca Turner, Ph.D.; Kate Walker; Idell Wilson.

BOARD MEMBERS ON LEAVE: chance martin; Sandy Yuen; Dennis Yun, M.S.W.

BOARD MEMBERS ABSENT: none.

OTHERS PRESENT: LaVaughn King; Bob Cabaj (Director of Community Behavioral Health Services); Helynna Brooke (MHB Executive Director); Rich Snowdon (MHB Administrator)

1.0 WELCOME AND INTRODUCTIONS

The meeting was called to order at 9:10 a.m. by Ted Stinson, Chair.

Mr. Stinson: Good morning everyone! I appreciate you being here on time, and the fact that you are willing to give your day to this work is a strong testament to your dedication.

It's important when a doing retreat like this to look back and see what we've accomplished, and then to look forward to the future.

I want to say thank you on behalf of the City and County of San Francisco for giving your time. I think you are all doing something very important for the Mental Health Board and as citizens of the nation.

I want to introduce LaVaughn King who is here with us today. We've been told that she might be appointed by Supervisor Newsom, and his staff asked that she be able to attend today to have input into the planning process. Then the official announcement of an appointment will be made after the election.

This afternoon we'll be picking our priorities for 2004 and I want to encourage using a laser focus. We have so little time when you think about the magnitude and the complexity of some of these issues we work on. The more we can be very focused in picking priorities, the more we'll be successful as a Board.

Our goals for today include:

1. Getting a sense for how we did this past year. We'll spend some time in reflection, looking at how we were effective and how we were less effective. What makes an organization effective is self evaluation done in a spirit of improvement not criticism.

2. Looking toward the future, to understand what's important for us as a Board in this next year, and coming to consensus.

3. Finally, what makes a group function effectively is some degree of a personal bond between people. We have so little time during the year, so I urge you to take advantage of our time together today to get to know each other better and to develop new relationships.

I'd like to thank Helynna and Rich for their incredible work. They are key contributors to what we do. The fact that we get not average work but exceptional work from them is a testament to what we do as a Board. We appreciate the work you do and thank you for it.

Ms. Brooke: I tell people I have 17 bosses and I love all of them.

2.0 A LIGHTER MOMENT
Next on the agenda was a performance by Board member Bob Douglas, known professionally as the Crippled Comic.

3.0 GETTING TO KNOW EACH OTHER
Each Board member was asked to share a story of a time when they made a contribution to the community or an individual.

4.0 YEAR IN REVIEW
Mr. Stinson: I wanted to begin by reading you a message that was on the MHB voice mail yesterday morning:

"Hi! This is Jo Ruffin. I was just calling to thank you for sending me the minutes of your meetings during this past year. I've been really very proud of you and impressed with the work you've been doing.

I wish you all well at your planning retreat tomorrow. I will miss you. I'll miss being part of that process. But I'm enjoying retirement.

And again, thank you for including me on your mailing list and I wish you good luck for this coming year."

Jo's compliments around what we achieved in the past year are a reflection of what I feel personally we have accomplished. I want to go through those with you using these PowerPoint slides:

2003 MENTAL HEALTH BOARD PRIORITIES

Advocacy for the mental health budget

Participation in planning for integration into the new Community Behavioral Health Services (CBHS)

Monitoring the implementation of Proposition N, "Care not Cash"

Increasing the hours of operation of Mobile Crisis to 24/7 and establishing a 24/7 Drop-in Center

What did we accomplish this year?

BOARD SPEAKERS AND PRESENTATIONS

January
Behavioral Health Court: Judge Harold Kahn

February
Debate on the Implementation of Care Not Cash and its impact on mentally-ill persons:

Dariush Kayhan, Department of Human Services
Jennifer Friedenbach, Coalition on Homelessness

MHRF staff led discussion regarding the closing of the Mental Health Rehabilitation Facility (MHRF)

March
Mental Health Rehabilitation Facility (MHRF): Mozettia Henley, Director

April
The public health budget and the integration of Community Behavioral Health Service: Barbara Garcia, Deputy Director, Department of Public Health

May
Family Mosaic Program: Roban San Miguel, Executive Director

June
Revenue collection and enhancement for CBHS:
Michelle Ruggels, Director of Operations, Community Behavioral Health Services

July
Dialetical Behavior Techniques with Cognitive Mental Illnesses:
Blanche Korfmacher

Recommendations for Joint Advocacy Efforts Across Stakeholder Groups:
Janice Cohen, M.D.

August
No meeting - summer vacation

September
Behavioral Health Court Update: Judge Susan Breall

October
Proposed Charter Amendment regarding the Health Department Budget and Structure: Supervisor Chris Daly

Mental Health Issues At Youth Guidance Center:
Gwendolyn B. Tucker, Chief Probation Officer of the Juvenile Probation Department

November
AB 1421 and Behavioral Health Court: Discussion and debate by Board members

RESOLUTIONS

January 2003
Resolution honoring Michael Isip and KQED for their program "Hope on the Street."

March 2003
Resolution responding to the Budget Crisis
This resolution was endorsed by:
Mental Health Association, San Francisco Chapter
National Association for the Mentally Ill, San Francisco Chapter

April 2003
Joint Budget Resolution supporting the budget of the entire Department of Public Health. It was the first time ever that the four advisory boards have done a resolution together:

The Mental Health Board
The Treatment on Demand Planning Council
The Citywide Alcoholism Advisory Board
The Drug Abuse Advisory Board

May 2003
Resolution to ensure quality physical and mental health services for our returning service people.

June 2003
Resolution of special commendation to Officer Mike Cowhig for his work as psychiatric liaison.

Resolution of special commendation to Supervisors Daly and Maxwell for taking a busload of advocates to Sacramento on May 15, 2003.

November 2003
Resolution of support for the Behavioral Health Court.

PROGRAM VISITS AND REVIEWS

Next Door
Jackson Street Residence
Recreational Center for the Handicapped
Mental Health Rehabilitation Facility
La Amistad
Mission Family Center 1
7th Street House
Chinatown/North Beach Mental Health Clinic
St. Francis Hospital Inpatient
St. Lukes Hospital Inpatient
Tenderloin Clinic
Crossroads Residential

ANNUAL REPORT AND ANNUAL RECEPTION

The Annual Report 2003 focused on the budget crisis, the departure of Jo Ruffin from CMHS, the new director of Community Behavioral Health Services, Bob Cabaj, and the Mental Health Court. The report included the full text of the Mental Health Board's budget resolution.

The Report was released on May 15, 2003, at the Board's Annual Reception in the Mayor's Conference Room at City Hall. The Mayor, the Supervisors, and the staff to the Supervisors were invited as well as key administrators from the Department of Public Health.

This year we invited the following groups to co-sponsor our Reception:

Mental Health Association, San Francisco Chapter
National Alliance for the Mentally-Ill, San Francisco Chapter
DPH Treatment on Demand Council
DPH Citywide Alcoholism Advisory Board
DPH Drug Abuse Advisory Board

Supervisor Fiona Ma and Supervisor Jake McGoldrick attended and spoke to the group. Staff for Supervisors Maxwell, Peskin, and Sandoval attended. Mayoral Candidates Angela Alioto and Tony Ribera came and spoke.

OUTREACH MEETINGS
Supervisor Tom Ammiano
Supervisor Chris Daly
Supervisor Matt Gonzalez
Supervisor Fiona Ma
Supervisor Sophie Maxwell
Supervisor Jake McGoldrick
Supervisor Gavin Newsom
Supervisor Aaron Peskin

POLICE CRISIS INTERVENTION TRAINING
In partnership with the San Francisco Police Department, the Mental Health Board helped run four PCITs - in January, April, July, and October.

The following Board members participated in the trainings: Kate Walker, Carol Knight, Bridgett Brown, Dennis Yun, Idell Wilson, Augusta Del Zotto.

The Board provides the fiscal administration for the PCITs.

PROGRAM AND SERVICES AND CHILDREN'S COMMITTEE
Highlights

July: Sai-Ling Chan-Sew, Director, Child, Youth and Family Section, CBHS

September: Victor Damian, Youth Task Force

October: Keith Hutchinson, School Liaison Director in the Bay View

ADDITIONAL ITEMS
In January, the Board was recognized by Jo Ruffin as a Mental Health Hero for its work with the PCIT.

In August, Sgt. Mike Sullivan and Helynna Brooke were the guests on the Gene Burns show on KGO and talked about the PCIT and the need for 24/7 Mobile Crisis Services. KGO has more listeners than any other station in the Bay Area.

In September, Bob Douglas represented the Board at the meeting of the California Association of Local Mental Health Boards in San Jose.

In October, Augusta Del Zotto, Toye Moses, and Bob Douglas met with the Treatment on Demand Planning Council about strategies for integrating the work of the advisory boards.

With regard to Board presentations, you can see the breadth of issues we covered. Each Board meeting was directly designed to take on a substantive issue. We did a really nice job of staying on priority. At the same time, as issues came up, we were nimble and responsive. I'm specifically thinking about the issue of the Mental Health Rehabilitation Facility and Supervisor Daly's proposed Charter Amendment on the Department of Public Health. To me that's a reflection of a well functioning organization, when you can say we had priorities but we've now adjusted those priorities because of new things that have arisen.

Similarly we've had a fairly productive year in terms of resolutions. We covered a broad range of topics. The one resolution that's especially noteworthy was the one put forth in April. I want to say thank you and give recognition to Rich and Helynna for their work on this. The Joint Resolution on the Budget was developed by MHB and then we took it to the other advisory boards and they passed the same resolution. This is the first time in history that this has been done. It's a visible sign of how we see ourselves continuing to work more closely together in the future with the other advisory boards.

There's also a nice breadth of programs that Board members have visited in this past year. These programs represent the range of the programs in the system and the breadth of cultural competence. We have done a nice of job of not focusing on only one particular type of program, but instead we've reviewed the full range of programs.

With regard to our Annual Report and Annual Reception, these are two of the most visible statements we make in terms of policy. We were facing a very difficult budget crisis. I think we did an awfully good job of getting participation and interest.

In terms of integration, what we have instinctually been doing is moving forward in a collaborative manner with the other advisory Board. They co-sponsored not only the budget resolution, but also our Annual Retreat. This reflects the fact that we as a Board have recognized that there is much greater strength if we work with others who have similar interests and goals.

We met with a great percentage of the Supervisors. I think it impresses the Supervisors that we come speak to them, not as paid lobbyists, but as people who profoundly believe in what we are saying. Sometimes it feels like we are trying to move a mountain but that mountain gets moved inch by inch. We certainly have improved over the last few years in our effectiveness and will continue to improve in the future.

With regard to the Police Crisis Intervention Training (PCIT), we have been covering the gamut of involvement in this. We've been bringing together the mental health community and the police force, reflecting again this theme of working together collaboratively. We're engaging them rather than pushing against them in an antagonistic manner.

Finally, hats off to members of the MHB's Program and Services and Children's Committee for picking up the committee work that did not have a lot of interest, and giving it momentum. The fact that this is moving forward is a testament to those on the committee.

Now I'd like to initiate a general discussion. As Board members there is benefit to looking in a constructive manner back over this past year. I see a number of accomplishments, but I think we can do more. I'd give us a B+ for this past year.

Let's see if we can increase the number of programs we visit and meetings we do, and the number of resolutions. If we can increase by 10-15%, that'll be a great improvement.

Ms. Knight: Thank you very much for the presentation. It was really helpful. Helynna dragged me onto this Board and I want to thank her. This is something I've never done in my life before. I've never spoken in public, have never done politics, and have never spoken to Supervisors. But I am a die-hard advocate. I know we are all advocates, but I think we could do more. I know Kate has expressed that, too.

In the three months of the Committee meetings, only a small number of people have showed up. But if we don't have the participation, we can't do as much advocacy.

Maybe after each presentation or guest speaker, we might think about an action function in that area to do between that meeting and the next. Even at the committee level where the action should be implemented, I haven't seen that much action.

Dr. Turner: I've only been here three months, and this looks good to me. But I also think more can happen. I think it would help to clarify expectations around committees. People are doing things on their own, but it might be possible to form task forces around particular issues. Sometimes if you go to events in twos or threes, there's some accountability about why we went and what we accomplished.

Ms. Walker: I agree. After we hear a speaker, what do we do with it? I'd like to have time to look at action. We could have a temporary committee, for example, to examine Behavioral Health Court. If there are some Board members who would like to work with each other, they ought to have a chance to meet and discuss issues and report back to the Board.

About resolutions, is it now that Helynna makes the resolutions? Is that the way the Board works?

Mr. Stinson: This is a good question. The Board should understand the way the things they are voting on come to the Board. Regardless of the source everyone should feel accountable on what you vote on, and to understand what you are voting on.

Here are three ways a resolution can come before the Board:

1. Helynna and Rich, as part of their job description, write up resolutions in accord with Board discussions and requests.
2. Committees have for years written up resolutions and sent them on to the full Board.
3. Individuals can propose or write up resolutions.

Ms. Brooke: A fourth way is that an outside group might ask us to do a resolution. An example of that is our resolution on the Mental Health Services Act, in support of a state

ballot initiative to tax people earning over a million dollars annually to support mental health services. We have been asked by the sponsors of that initiative to support it in any way we can.

Mr. Stinson: I feel strongly there are many more things we can be doing with a little extra time. Like writing a note to a Supervisor or a letter to the editor. We as a Board are composed of individuals. There is no magic person behind the curtain. It's really a matter of each and everyone of you making the effort. Every one of you have your own life circumstances, but if you feel like you can give more, I encourage you to do that. If there is something you are passionate about I encourage you to support that.

Ms. Walker: Can an individual bring up anything they want in a meeting without the approval the Executive Committee?

Mr. Stinson: The Board is constrained by the Sunshine laws and so we operate entirely within those laws. It's okay to bring up a new item to recommend that it be placed on a future agenda. But we are not allowed to discuss or vote on items that are not on the agenda and that the public has not be given advance notice about.

Dr. Del Zotto: This past year, I think we were very helpful in keeping the Mental Health Rehabilitation Facility afloat.

Mr. Stinson: I went on a site visit there and it was very eye opening.

Ms. Brooke: If there are specific things you get interested in, or a program you take an interest in, contact Rich and me because we can help you make a connection. Please call on us to help you accomplish what you want to accomplish.

Mr. Stinson: What if we were to take the time set aside for our Board presentations and divide it to include 10-15 minutes after the presentation to talk about how we want to act on the presentation? For example with the Behavioral Health Court, having heard the presentation, what do we want to do about this? Perhaps writing a letter to the editor, or a couple Board members could investigate it more deeply.

Mr. Luebkeman: When we had our discussion on the Behavioral Health Court resolution. I found it really helpful that there was a member of the public who made insightful comments. I wonder if with presentations, we could have people representing both sides of the issue pro and con.

Mr. Stinson: In the two hour board meeting, are there things that are less important?

Dr. Del Zotto: Perhaps some of the in-house presentation can be left to the written report when possible. Sometimes the Director's report could be a written report.

Mr. Stinson: Do you still want Q&A?

Dr. Del Zotto: I appreciate CBHS administration being willing to answer questions, but it's often not that necessary.

Mr. Luebkeman: Often they are saying they don't know about something. Maybe a verbal report quarterly would be enough.

Mr. Douglas: I wouldn't object going to a 2.5 hour meeting, maybe starting at 6. Sometimes two hours doesn't seem like enough. I think we could change the committees into task forces dealing with specific issues. Maybe having a task force to go with each of the three biggest priorities to look into the issues more in detail. On a lot of boards I've been involved in, committees are often where the leg work gets done.

Mr. Luebkeman: Bob Cabaj often talks about things outside of budget issues. Maybe we could have a report on budget issues quarterly and then CBHS staff gets ten minutes for other issues at each meeting.

Mr. Stinson: Let me summarize. We're going to take a 30-minute block of time and pare it down to 5 minutes, either fielding questions the board may have about the written presentation or items of urgency. Once a quarter we'll have 30 minutes for a report on material issues.

Ms. Leung: One of the guests talked about how she had a very bad experience with one of the residential programs. I brought up whether there was any chance a follow up could be done. I don't remember who in that meeting represented CBHS. Is it appropriate to have a follow up on things like that?

Dr. Del Zotto: Many people could show up with complaints, and we're not in charge of the grievance process.

Ms. Brooke: If there is a complaint, we can take that issue to the administration of CBHS and to the director of the program.

We can send out the Director's Report with the Board packet the week before the meeting.

Mr. Luebkeman: We might formally adopt a policy statement at a Board meeting about our level of involvement in issues, complaints, and grievances.

5.0 PRESENTATION BY DR. CABAJ

Mr. Stinson: This is the second year Dr. Cabaj has joined us at our Retreat. Last year he had just been promoted. I want to begin by reading a bit of his bio:

> Dr. Robert Cabaj is the Director San Francisco's Community Behavioral Health Services. Prior to this position, he was the medical director. Before coming to San Francisco, he was with San Mateo County, as Medical Director of Mental Health Services. From 1991-1994, he was the Medical Director of the newly created Substance abuse Consult Service at San Francisco General Hospital. He is a Clinical Professor in Psychiatry at the University of California, San Francisco and the author of two books and many articles.
>
> Bob graduated from Harvard Medical School and did his Psychiatric Residency Training at Cambridge Hospital. Besides his interests in mental health and substance

abuse issues, he is an avid fan of classical music and opera, attending almost every concert held in San Francisco and collects CD's by the thousands! He commutes to most of his many meetings by bicycle.

Dr. Cabaj: Thank you. It seems like the year has gone by so fast. I didn't come with prepared remarks because I wanted to have an interactive dialog with you. I want to be at MHB meetings at much as possible. However, on the second Wednesdays of the month I attend the board meeting of the California Mental Health Directors Association. I've found that it's good to be on the inside track of that organization. They follow state legislation and do lobbying. I was able to get appointed to that Board. When I first came here to CBHS, Jo Ruffin said, "Stay on the state directors board; it's really important."

The year has zoomed by. Last year, we talked about integration. Two of my pet projects are: 1) patient flow and 2) advance access, which means easier and quicker entry into the mental health system. Both of these projects have happened in the last year.

We've officially been using the name Community Behavioral Health Services (CBHS) since the summer. The Health Commission reviewed our annual plan about how to integrate, and whole-heartedly supported it and said we could officially start.

Some people don't like the word "behavioral," but it's meant to be used in contrast to medical health.

Probably there will be administrative integration in the future, given how the City keeps cutting back on the budget for administration. A future goal is to work more closely with City clinics. If that happens, you'll know about it in plenty of time to look at it and what it means.

With regard to behavioral health integration, we'll get the plan out this summer. On January 5, 2004, we should be rolling out of the new organizational chart. We also wanted to get consultation about how to integrate. We've gotten lots of community advice and input from the advisory boards. Some people on staff have experience with integration. But given how big and complex our system is we can't hope to do integration ourselves, so we've been using consultants and we're going to put out an RFP for a major consultation contract.

The consultants we've been working with gave us a review a few weeks ago on November 10th and they think we are in a very good place to start doing the clinical integration. This will be a year-and-a-half to two-year process. We want all the clinical services ready to integrate fully in July 2005.

We'll be presenting an update to the Health Commission in March.

A key reason for integration is that the nature of the clients we're seeing has changed. We're now working with extremely disturbed clients with multiple problems: legal, health, and substance abuse. Looking at who's in our system currently means revamping the service package we give.

The government and funding sources are recognizing the need for treating co-occurring disorders within integrated services, and funding in the future is moving toward funding only for integrated services.

According to national statistics, of the clients in the public mental health system, 70% have co-occurring disorders, but often only 10% are recognized as such. So then the question gets asked, Why doesn't the client get better? Often it's because there's another unidentified issue going on, like substance abuse, either with the client or a close person in their life. And if that issue is not addressed then treatment is not going to be successful.

I'm thinking of a situation where I was consulting with a clinician who said the client's depression was not stopping. I asked, "What's the client's alcohol use?" The clinician replied, "Oh, I never asked that." Maybe the client is drinking himself to sleep every night and that's why the depression is not stopping.

In public substance abuse services about 50% of the clients have a mental health problem that is often not diagnosed either.

The more institutions and levels of care you've been involved in, the more likely you are to have a co-occurring disorder. If you've been in the criminal justice system, or through juvenile hall, or in more than one social service system, the more likely you are to have co-occurring disorders.

We'd at least like to have behavioral health care in the City clinics. For example at the Tom Waddell Clinic, more than half their work is behavioral health.

A huge amount of behavioral health care services are delivered in the city. Half of the primary care work is actually behavioral health care. So different parts of DPH need to be able to help each other out and work together more.

With regard to the organizational chart, we're not radically changing things. We're folding a lot of services into the overarching structure. All substance abuse services provided by the City are provided by contract agencies. This is as opposed to mental health services where 60-65% of services are provided by contract. We'll be shifting the balance to about 70-75% of all services being provided by contractors.

That means the staff in Community Substance Abuse Services are all contract monitors, and many do not have clinical expertise. Many are not licensed. Many are in recovery themselves and have came up from the roots. Substance abuse counselors become administrators.

The State is starting to require licensing, so now all SAS counselors need to be licensed, by the middle or end of 2005.

Rarely have the SAS contract monitors addressed the quality of the program, focusing instead on contractors meeting the numbers in their contracts. On the mental health side, there are client satisfaction surveys, quality reviews, reviews of extreme issues, such as deaths and medical setbacks, to follow quality of care.

SAS is excited that they can do more quality assurance work, and mental health can learn more about running contracts and making sure we get what we pay for.

The Patient Flow project is about moving people out of hospitals into the appropriate level of care. Some months we're doing well with this. One month we had 22 empty beds at SFGH, which hadn't happened in decades. One month we had no one in private hospitals. This saved a huge amount of money. Currently we have 31 people in the hospital who shouldn't be there, but we can't find proper placements for them.

Liz Gray is in charge of placements now. TAP, the Treatment Access Program, through which people come into substance abuse services, will be joined with ACCESS, through which people come into mental health services.

Sai-Ling Chan-Sew, the Director of the Child, Youth and Family Section of CBHS, will be responsible for all child-related mental health and substance abuse programs. Terry Ryan, who has been the lead person for child-related substance abuse programs will be working with Sai-Ling.

Linda Wang will continue as Adult Director.

Dr. Turner: I love this new idea of integration. It makes so much sense. Another kind of integration is around issues of housing and employment. How do you see further integration of these things that can make treatment be more effective.

Dr. Cabaj: Many of you know that San Francisco has about the only Department of Public Health in the country that includes housing. Marc Trotz is the Director of Housing for DPH. Even though it's never enough, San Francisco has one of the most extensive housing systems in the state, including Board and Care and residential treatment facilities.

Every year we lose more Board and Care programs because of the housing crisis. Homelessness is the big issue and housing is the answer, but how do you get more housing in the current housing crisis?

Dr. Del Zotto: Toye Moses, Bob Douglas, and I went to a meeting with the Treatment on Demand Planning Council to talk about issues of integration. One key question is about requirements for getting into programs. In some places around the country you have to meet every requirement to get into treatment, and so people are being left out of treatment they need.

Dr. Cabaj: No, we will not do that. We are focusing on accepting people into treatment not screening them out. The problem in the past has been not recognizing enough issues. Integration means starting with the assumption that everyone has a co-occurring disorder. But if you don't that's fine, you will receive treatment, too. But if we don't ask about all the issues in the initial assessment, we won't find out all the things the client needs in terms of treatment.

Our consultants are working with us on this. The picture of clinical programs won't look all that different. Some programs will be specific and focused, such as methadone programs or employment programs. There will still be a clean and sober house. But we want every client to have access to all the levels of care they need.

If you hear anyone using integration to screen people out, please alert us. We're not looking for ways to screen people out, but to bring people in and treat them properly. We will do a complete assessment to help people get to the services they need. We'll be saying, "Any door is the right door. Come on in. But the door you walk in, might not be door where you stay." And we'll help people get connected with services instead of leaving it up to them to find what they need on their own.

Josephine McCreary will be helping us make sure our contracts are monitored and done in a more timely fashion.

In terms of new training, we're waiting till we get closer to the actual integration of services, so people will learn new skills in a timely fashion.

In the assessments, we're going to be asking different questions. We'll find out more about the clients. It's not that we'll see radically different kinds of clients coming in. Currently, every clinic has to deal with people who come in intoxicated and disruptive. There's already a whole routine for that.

We believe this integration will give us more humane interactions with clients and will help with engaging clients in treatment.

Under the new Advanced Access, the target is access to care within two days. Most clients are getting access in one day. That has lead to people feeling welcomed, engaged, and coming back. There are fewer no shows. I've been meeting with each clinic. The staff in the past have counted on a certain number of no shows to get other work done. But that's not what we're here for. Direct treatment of clients comes first.

I have heard some mental health staff say. "We don't need to see people who use alcohol and drugs. They don't deserve care." I couldn't believe they were actually saying it in front of me.

I've heard some substance abuse counselors say, "These crazies come in and we don't know what to do with them."

A lot of the training is going to be attitudinal, helping people get comfortable with the full range of clients we serve.

Dr. Moses: It's almost a year ago that we welcomed you to your new position. I'm glad to see the action you've taken and want to commend you.

You recognized Terry Ryan. She's well known and highly respected. I'm glad you are giving her more responsibility.

We'd like to see more diversity in CBHS. I know you will do your best.

As you know, the Mental Health Board advocates for consumers and also providers. Some providers are having a hard time keeping up given that we are in difficult economic times. CBOs are more efficient than we City workers are. How can we support them?

Dr. Cabaj: That's one of the things that concerns me the most. Especially with the blending of services, the majority of our care will be through contracts.

I was justp out at the Bay View clinic. They said to me, "As soon was we train someone well, the City hires them away with better pay." This is a number one issue and we've raised it over and over. The contract agencies have not been given a COLA for years. We keep asking them to provide the same services, but with no increase. But that translates to about a 10% cut because they need to increase their funding about 10% every year to keep up with rising costs.

The City keeps telling me it's not likely we'll be able to do COLAS. But we are going to get a very disgruntled and angry set of providers if we don't find a way to address that. If the City proposes a COLA for contractors but not City staff, then City unions get upset. We want to be poised to help influence the new Mayor around this issue.

Mr. Stinson: These are tight budget times. What are ways DPH can be smarter about the money it spends and about creating efficiencies?

Dr. Cabaj: One of our new committees will be looking at revenue enhancement. Mental health services is the biggest money maker for the city, bringing in much more money, than primary care. SAS is almost entirely funded by General Fund money.

However, there is Medi-Cal for substance abuse issues and we're going to be making better use of that.

We've started making a few clinics work very hard on getting people eligible for Medi-Cal and SSI. We've analyzed a list of chronically ill clients and found 4,000 are not on Medi-Cal or entitlements. Why not? Probably almost everyone of them should be on benefits. If we could get 3,000 on SSI, it would be a huge revenue boost. This is a matter of millions of dollars.

We're looking at the impact of things like workers comp, which costs $12 million a year for public health staff. And that's often the amount we cut from the budget.

Our pharmacy is doing a lot of work on trying to get free medications. Some of the newer medicines we can't get because they are not on the Medi-Cal list. We were $1.5 million over budget on mental health medications last year.

We're also looking at billing. We have a lot of disqualified billing. We want it done correctly so it will bring in the revenue we need. We want to make sure the system is compliant and doing it right for legal reasons, too.

Dr. Del Zotto: Are you planning to do an assessment or screening of the private clinicians on contract with you? This year I identified several who are doing less than satisfactory work.

Dr. Cabaj: If you have information like that, it should go to Josephine McCreary. We do reviews of each clinician and if we hear specific concerns then we can target them. We've identified a few providers who are problems. One man was way over on the billing he was charging.

Dr. Del Zotto: One clinician often does not show up for clients but still bills.

Dr. Cabaj: We work hard to cut out the abuse and fraud. I like to believe there's not much in San Francisco, but we want to stop any of it that does exist.

Mr. Luebkeman: When there is a merger there is the hope that it will be even, but always the stronger personalities tend to get the priorities. How do you insure that one area doesn't dominate the other in the merger?

Dr. Cabaj: You're raising the fears of the substance abuse staff. One person was spreading a rumor that we are here to eliminate substance abuse services. When you read my background, you see my work with the substance abuse consultation, and that I set up the detox unit at SFGH. And you see my work with substance abuse services in San Mateo County.

Substance abuse services is actually my real heart as a subject. When I was a medical student, the first people I saw who got better were in the substance abuse clinic. People truly got their lives together. They learned about being clean and sober. I was so impressed.

I try to convey this to my staff, that integration will be an enhancement for both substance abuse and mental health.

Ms. Shaffer: You mentioned mental health and substance abuse and making some type of entry assessment and you mentioned primary care. It's so interesting how our children are assessed in adolescent clinics, how much the clinicians ask and how many tests they do.

Dr. Cabaj: Yes, we're going to revise our standardized assessment. We would like to have someone at each primary clinic to provide substance abuse and mental health services.

Community based agencies can do 24-hour care better than a City clinic. For example, Citywide Case Management. CBOs pay staff less than city workers, so the City gets more for its dollar at contract agencies, at the expense of the agencies.

We want to handle contracts in a more efficient way. For example, Westside Community Mental Health has many programs. They've had different program monitors for different programs. We want there to be only one monitor for each agency,

or at most two, it is an especially complex operation. In the past contract monitors working with the same agency didn't talk with each other.

We did a study at the Southeast Clinic. Many clients are being seen by other agencies. For the whole client base there were 242 other providers, but almost none ever communicate with the staff at Southeast.

Ms. Shaffer: Often the family has to manage the case managers. It's almost another stressor. Dr. Cabaj: We found one family who had eight case managers, but not one of them was seeing the child. This is the kind of thing we want to prevent.

Mr. Douglas: Are we moving toward the day when we provide primary care with mental health services? Dr. Cabaj: We're probably moving in that direction. The Chinatown Clinic and the Chinatown/North Beach Mental Health Center are working on bridging that gap.

Dr. Moses: What will be our fate as the Mental Health Board under integration? By law there has to be a Mental Health Board for each county. Have you sought legal advice?

Dr. Cabaj: Part of Barbara Garcia's goal is more consolidation. There have been four advisory boards. There are state mandates and city mandates. I don't see why we have the CAAB and DAAB. Those worlds are not so separate. Treatment on Demand has taken a slightly different approach. At some point they might create one broad-based substance abuse board. Maybe that's as close as we can get to integration. I know you are all working together more closely.

LUNCH BREAK

6.0 STRATEGIC PLANNING FOR 2004

Mr. Stinson: This afternoon we'll be setting the direction for the Board for 2004. We'll be using a three stage process. First, we'll be brainstorming possible priority issues. Then we'll discuss the issues in some detail. Then we'll be choosing our top priorities.

BRAINSTORMING
Mental Health Budget
Mobile Crisis 24/7
Less visible mental health issues: depression, suicide prevention
Behavioral Health Courts
Promoting group treatment
Youth focus
Mental health stigma and the process of integration
Mayoral education: plan for educating the new Mayor about state of mental health services for his first month in office.
Board of Supervisors Education
Community Education
Examination of private mental health services
Look at how people come to the county from private health plans
Vocational training and work and employment opportunities for mental health clients

Self-sufficiency
AB 1421 - involuntary outpatient treatment
Intersection between homelessness and mental health
Dealing with complaints brought to the board
CBHS review of complaints
School district: go to schools, invite youth and parents to the Board, children of mentally-ill parents
Public Guardian
Elderly
CALMHB
Psychotropic medications, their effectiveness and cost, their role in treatment.
Diversity of treatment options, alternative treatments.
Collaborate and network with like-minded groups like SPUR and mental health organizations.
More consumers working in mental health
Pay scale of mental health workers - brain drain
Police Crisis Intervention Training and other police issues
City social services and the mentally ill, and school district issues
Monitoring integrated services
Training jail personnel along with police. (Article in the paper on 11/16 about the jail being the largest outpatient treatment facility.)
Advocate for clients in jail.
Advocate for child offenders at Youth Guidance Center.
Monitoring of services provided by neighboring counties. Lack of service impacting San Francisco caseload. How many of our clients are outside the area?
Intergenerational mental health issues.
Patient flow and revenue enhancement - oversight of efficiency
Women's mental health: single parents, fear of removal of children, women only treatment
Special populations
24/7 Drop-in Center
Working partnerships with public and private organizations such as SPUR
Add a youth to the Board (18 years old)
Using groups in programs
Mental health stigma
New medications not on Medi-Cal formulary
Keeping consumers and peer counselors working in Substance Abuse Services, dealing with the state licensing issues.

Board training
- Sunshine Ordinance
- Information on integration
- Re-orientation to the Board
  - clarifying roles
  - being an effective Board out in the community
  - CMHPC training for Mental Health Board members in January
- Key statistics about the system

Wallet-sized cheat sheet
- mission of the Board

what you can say or not
hearing for consumers to come and speak
informational meeting
town hall meeting

Supervisor Dufty: The Mental Health Board can do a hearing and make a presentation. It will be televised on GTV and three Supervisor will be there to hear your message. This can be a good way to reach Supervisors because an awful lot of paper moves through City Hall.

STRAW VOTE ON PRIORITIES

MOBILE CRISIS - 6
WOMEN'S MENTAL ILLNESS - 4
SCHOOL DISTRICT - 4

The City budget for mental health services is already a mandate for the Mental Health Board and is automatically included as a priority.

Ms. Shaffer: With regard to the School District, teachers need training. Parents at home can be mentally-ill and children can be acting out in school. When you bring up the word "depression," teachers don't recognize it in children. They're not little adults. There are "invisible" illnesses. There are children who are not acting out but need treatment. They can be overachievers. The School District does not know what to do. Kids with mental illnesses are tracked into non-academic tracks.

7.0 ADJOURNMENT

Mr. Stinson: I think we have accomplished our goals for the day:

1. We've reviewed the past year.
2. We've set priority goals for 2004, which we will officially vote on at our meeting on January 14th.
3. We've gotten to know each other better.

Thank you to everyone!

There being no further business, the retreat was adjourned at 3:45 p.m.